NORTH PUGET SOUND MRI

# MRI SCREENING FORM

**Name:** _____ **Sex:** _____ **DOB:** _____

**Exam Type:** _____**Exam Date:** _____**Height:** _____**Weight**_____

***The following items may be harmful to you during your MR scan or may interfere with the MR examination. Please provide a "yes" or "no" answer for every item. All patients: please complete the green section and sign and date on the back side of this form. Complete the blue section only if you are receiving IV contrast.***

| YES | NO | |
|---|---|---|
| ☐ | ☐ | **Claustrophobic? If yes, is oral sedation required?** _____ |
| ☐ | ☐ | **Able to walk and stand unassisted?** _____ |
| ☐ | ☐ | **Cardiac pacemaker or implanted cardiac defibrillator, internal electrodes or wires** |
| ☐ | ☐ | **Neurostimulator implant (spinal cord stimulator)** |
| ☐ | ☐ | **History of heart surgery? If yes, where and when:** _____ |
| ☐ | ☐ | **Artificial heart valve, coil, filter and/or stent** _____ |
| ☐ | ☐ | **Aneurysm clip(s) or coils** |
| ☐ | ☐ | **History of head/brain, eye or middle/inner ear surgery?**<br>**If yes, where and when:** _____ |
| ☐ | ☐ | **Shunt or programmable pressure valve** |
| ☐ | ☐ | **Artificial eye and/or eyelid spring** |
| ☐ | ☐ | **Eye injury from a metal object (metal shavings, metal slivers)**<br>**If yes, was it removed or any MRI's done since:** _____ |
| ☐ | ☐ | **Ear (Cochlear) implant, middle ear implant** |
| ☐ | ☐ | **Hearing aid(s)** |
| ☐ | ☐ | **History of surgery to the area of body being scanned today?**<br>**If yes, where and when:** _____ |
| ☐ | ☐ | **Artificial joint or limb, implanted hardware (pins, rods, screws, plates, spinal cage,)**<br>**If yes, please list:** _____ |
| ☐ | ☐ | **Surgical clips, staples or surgical mesh, or non-metallic implants.**<br>**If yes, please list:** _____ |
| ☐ | ☐ | **TENS unit, spinal cord stimulator, bone growth stimulator** _____ |
| ☐ | ☐ | **Implanted or external medication/drug pump** _____ |
| ☐ | ☐ | **IV access port or catheter (Port-a-Cath, PICC line, Swan-Ganz)**_____ |
| ☐ | ☐ | **Radiation seeds or tumor markers (cancer treatment)** _____ |
| ☐ | ☐ | **Personal history of cancer:** _____ |
| ☐ | ☐ | **False teeth/dentures, metallic removable dental work, braces, retainers**<br>**If yes, list:** _____ |
| ☐ | ☐ | **Any type of implant held in place by a magnet** _____ |
| ☐ | ☐ | **Injured by a metal object (shrapnel, bullet, BB) and required medical attention** |
| ☐ | ☐ | **Medication patch (nitroglycerine, nicotine, contraceptive, estrogen)** |
| ☐ | ☐ | **Tissue expander (breast), Penile implant, IUD, diaphragm** _____ |
| ☐ | ☐ | **Body piercing, tattoo or permanent makeup** _____ |
| ☐ | ☐ | **Wig, hair implants, hair pins** _____ |
| ☐ | ☐ | **Female Patients: Are you pregnant? Date of last menstrual period:** _____ |
| ☐ | ☐ | **List prior imaging to area being scanned:** _____ |

**Only answer the following questions if you are receiving an IV contrast or arthrogram injection:**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | **Kidney disease (renal insufficiency, solitary kidney, renal cancer, dialysis)** |
| ☐ | ☐ | **Diabetes. Taking medication to treat? _____** |
| ☐ | ☐ | **Hypertension. Taking medication to treat? _____** |
| ☐ | ☐ | **Severe liver disease (related to chronic or acute kidney disease)** |
| ☐ | ☐ | **Drug allergy, type: _____** |
| ☐ | ☐ | **History of anaphylactic shock or severe allergic reactions?<br>If yes, describe: _____** |
| ☐ | ☐ | **Have you had an MRI or CT/X-ray contrast injection before?** |
| ☐ | ☐ | **Allergic reaction to MRI or CT/X-ray contrast?<br>_____** |
| ☐ | ☐ | **Female Patients: Are you breastfeeding?** |
| ☐ | ☐ | **Taking any blood-thinning medications? _____** |
| ☐ | ☐ | **Needle phobia or fainting near needles? _____** |

**ALL PATIENTS: Please complete the following section:**

**Please discuss any concerns and/or questions you may have with your MRI Technologist or the MRI Assistant.**

**I attest the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.**

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**Patient Signature, Date and Time**

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**Parent or Legal Guardian Signature, Date and Time**