OPEN MRI of Decatur

MAGNETIC RESONANCE IMAGING (MRI) PATIENT PROCEDURE SCREENING FORM

Date ____ / ____ / ____ OMRI Medical Record Number _____

Name _____ Age _____ Height _____ Weight _____
Last Name First Name Middle Initial

Date of Birth ____ / ____ / ____ ☐ Male ☐ Female

Body Part to be Imaged _____ If applicable, which body part? ☐ Left ☐ Right

Reason for MRI and/or Symptoms _____

_____

How long have you been having these symptoms? _____

WARNING

Certain implants, devices or objects may be hazardous to you and/or interfere with the MRI procedure (i.e. MRI, MR Angiography, functional MRI, MR spectroscopy). Do Not Enter the MRI scan room or environment if you have any questions or concerns regarding an implant, device or object. Always consult the MRI Technologist BEFORE entering the MRI scan room.

☐ Yes ☐ No Do you have a Pacemaker, Pacing Wires, ICD (Implantable Cardioverter Defibrillator)

☐ Yes ☐ No Brain Aneurysm Clip(s), coil or graft
If Yes – Date of Surgery _____ Name of Hospital_____

☐ Yes ☐ No Cochlear, otologic or other ear implant/surgery

☐ Yes ☐ No Have you received dialysis for kidney/renal failure

☐ Yes ☐ No Do you have any of the following conditions, If **YES** mark what you do have:
☐ Kidney diseases / surgery ☐ Diabetes ☐ Lupus ☐ Acute Kidney Injury ☐ Sickle Cell Anemia

1. Have you had prior imaging of any kind to the area being scanned? (X-ray, CT, MRI, Ultrasound or PET) ☐ Yes ☐ No
   Date _____ / _____ / _____ Type of Exam _____
   Date _____ / _____ / _____ Type of Exam _____
2. Have you had prior surgery of any kind to the area being scanned? ☐ Yes ☐ No
   If Yes, please indicate the date and type of surgery:
   Date _____ / _____ / _____ Type of Surgery _____
   Date _____ / _____ / _____ Type of Surgery _____
3. Do you have a personal history of cancer? ☐ Yes ☐ No
   If Yes, what type:_____
4. Are you allergic to any medications/ drugs? ☐ Yes ☐ No
   If Yes, please list:_____
5. Have you ever had a reaction to contrast material or "dye" used for a MRI, CT or X-ray examination? ☐ Yes ☐ No
   If Yes, please explain:_____
6. Do you have asthma, seasonal allergies, allergic reactions or respiratory disease? ☐ Yes ☐ No
   If Yes, please explain:_____
7. Do you have claustrophobia or anxiety regarding your MRI examination? ☐ Yes ☐ No
   If Yes, please explain:_____
8. Are you taking any medication to help you through the exam due to claustrophobia? ☐ Yes ☐ No
   If Yes, please list:_____
9. Will you be able to lie flat for at least 45 minutes? ☐ Yes ☐ No
10. Do you have breast implants? ☐ Yes ☐ No
    If Yes, ☐ **Saline** ☐ **Silicone**

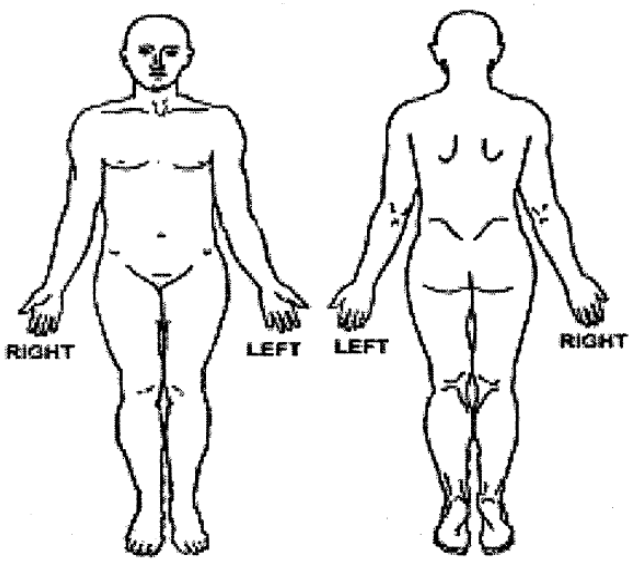
For female patients:

11. Date of last menstrual period: _____ / _____ / _____ ☐ Peri-menopausal ☐ Post-menopausal
12. Are you pregnant or is there any chance that you could be pregnant? ☐ Yes ☐ No
13. Are you experiencing a late menstrual period? ☐ Yes ☐ No
14. Are you currently breast-feeding? ☐ Yes ☐ No
15. Do you have an IUD, Diaphragm or Pessary? ☐ Yes ☐ No
    If Yes, what type:_____
16. Are you receiving hormonal treatment? ☐ Yes ☐ No
    If Yes, please describe (Tamoxifen, Aromatase Inhibitors, etc):_____

Please indicate if you have any of the following:

☐ Yes ☐ No Internal Electrodes or Wires
☐ Yes ☐ No Electronic/magnetically activated implant
☐ Yes ☐ No Eyelid Spring, wire or weight
☐ Yes ☐ No Metallic stent or filter
☐ Yes ☐ No Vascular Access Port and/or Catheter
☐ Yes ☐ No Shunt (Spinal or Intraventricular)
☐ Yes ☐ No Any type of internal stimulator
☐ Yes ☐ No Implanted drug infusion device or pump
☐ Yes ☐ No Bone/Joint pin, screw, nail, wire, plate
☐ Yes ☐ No Joint replacement (knee, hip, etc.)
☐ Yes ☐ No Surgical staples, clips or metallic sutures
☐ Yes ☐ No Wire mesh
☐ Yes ☐ No Radiation seeds or implants
☐ Yes ☐ No Any type of prosthesis (limb, eye, penile, etc.)
☐ Yes ☐ No Tissue expander
☐ Yes ☐ No Injury/removal of metallic object/fragment from eyes
☐ Yes ☐ No Injury by a metallic object or foreign body
☐ Yes ☐ No Tattoo or permanent makeup
☐ Yes ☐ No Breathing problems or motion disorder
☐ Yes ☐ No Heart valve
☐ Yes ☐ No Other implants
☐ Yes ☐ No Dentures or partial plates

Please mark on the figure(s) below
the location of any **implant or metal**
inside of or on your body.



These items must be removed prior to entering the scan room

☐ Yes ☐ No Medication Patch (Nicotine, Nitroglycerin, etc.)
☐ Yes ☐ No Hair pins or Wig
☐ Yes ☐ No Body piercing jewelry
☐ Yes ☐ No Hearing aid

IMPORTANT INSTRUCTIONS

You **must** change into hospital provided clothing. Ear plugs will be provided and must be worn during the examination. Before entering the MRI environment or MRI system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing, watch, safety pins, paperclips, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clippers and tools.

Please consult with the MRI technologist if you have any questions or concerns **BEFORE** you enter the MRI scan room.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form, and regarding the procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date: _____ / _____ / _____

Form Completed By: ☐ Patient _____ ☐ Nurse ☐ Relative_____
Print Name Relationship to Patient

MRI Staff Only

☐ Criteria for checking labs not met Lab Exam Date: _____ / _____ / _____

Creatinine Level: _____ Estimated Glomerular Filtration Rate (eGFR): _____ (via eGFR calculator website)

Contrast Name: _____ Contrast Amount: _____ (mL) (Confirmed by dose calculation chart)

Contrast Lot Number: _____ Injection site: ☐ Left ☐ Right

Reviewed By: _____ _____
MR Technologist Printed Name MR Technologist Signature