Name: Date:
DOB:
Chart:

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MRI SCREENING FORM

Name of Patient: ______________________ Date of Birth: ______________
Patient Account Number: ______________________ Patient's Weight: ______________
MRI Exam Ordered: ______________________ Patient's Height: ______________
Ordering Doctor: ______________________
Diagnosis: ______________________

Patient History:

Please indicate your response, to the below questions, by writing Y for Yes and N for No on the lines to the left of each question.

If you answer Yes to any of the next four questions then an MRI CANNOT be performed.

_____ 1 Do you have, or have you ever had a heart pacemaker?
_____ 2 Do you have any electrodes implanted in your body?
_____ 3 Do you have cochlear implants?
_____ 4 Do you have aneurysm clips in your head or neck?

The following questions are extremely important. There is a significant risk of permanent eye damage for patients who might have gotten metal in their eyes.

_____ 5 Have you ever had an object that may have been metal strike your eye?
_____ 6 Did you need to seek medical attention at that time?

If the answer to both questions 5 and 6 are Yes then the patient must obtain x-rays of the eye to screen for metal.

_____ 7 Have you had surgery recently? If Yes, when? ______________
_____ 8 Do you have a history of cancer?
_____ 9 Do you have a history of kidney disease? If Yes, patient will need blood work before scheduling.
_____ 10 Are you on kidney dialysis? If Yes, patient must be dialyzed within two hours following Gadolinium injection.
_____ 11 Is there any chance that you are pregnant?
_____ 12 Are you breastfeeding?
_____ 13 Have you ever had brain surgery? If Yes, when? ______________
_____ 14 Do you have an artificial heart valve? If Yes, what type? ______________
_____ 15 Do you have heart stents? If Yes, when? (must be 8 weeks post-op) ______________
_____ 16 Do you have any metal, electronic implants or prostheses in your body?
_____ 17 Have you had any other operations?
_____ 18 Do you have any problem with claustrophobia? If Yes, please give your pharmacy phone number to the nurse will be ordered. and a Valium script
_____ 19 Are you allergic to any medications? If Yes, what? ______________
_____ 20 Have you ever had a MRI with contrast? If Yes, did you have any type of reaction? ______________
_____ 21 Do you have sickle cell anemia? If Yes, then no Gadolinium injection.
_____ 22 Do you have a Neurostimulator Device?
_____ 23 Are you wearing a medication skin patch? If Yes, what type? ______________
_____ 24 Do you have a cast on the body part where the MRI is to be done? If Yes, patient must schedule for when a cast tech is present to remove and re-apply the cast.
_____ 25 Did the ordering Doctor take x-rays recently? If Yes, when? ______________
_____ 26 Are you able to lie flat for approximately an hour?
_____ 27 Who answered these questions? ______________ If other than patient, relationship? ______________
_____ 28 Who completed this form? ______________ If other than patient, relationship? ______________