MRI SCREENING FORM

Patient Name: _____ Date of Birth: _____

Patient's weight: _____ Patient's Height_____

- Have you ever in your lifetime had metal in your eye or had metal removed from your eye by a physician?
  Yes / No
  (If yes, it is required to do an orbital X-rays prior to the MRI unless you can provide a negative orbit X-ray report)
- **Are you claustrophobic (fear of being in a confined place)? Yes / No**
- **Please list previous surgeries and when they were done:**

_____

_____

- **Please circle Yes or No to all of the questions below:**

Pacemaker or Defibrillator	Yes / No	Dentures	Yes / No
Artificial heart valve/stents	Yes / No	Hearing aids	Yes / No
Aneurysm clips in head or neck	Yes / No	Shrapnel/bullet	Yes / No
Internal or external devices	Yes / No	Tattoo	Yes / No
Infusion pumps	Yes / No	Medicine patches	Yes / No
Eye prosthesis	Yes / No	Neuro Stimulator	Yes / No
Cochlear implants	Yes / No	Chance of pregnancy	Yes / No
Brain surgery	Yes / No	Artificial limbs	Yes / No
Personal history of cancer	Yes / No	Electrode implants	Yes / No

Please explain if answered yes to any of the above questions:

_____

_____

**** If the MRI has been ordered with contrast, please answer the questions below: ****

- Have you ever had MRI contrast? Yes / No If yes, did you have any type of reaction? Yes / No
- Are you breastfeeding? Yes / No

If answered yes to any of the questions below, you will need blood work prior to MRI.

Diabetes	Yes / No	Hypertension	Yes / No
Sickle cell anemia	Yes / No	Liver or kidney disease/dialysis	Yes / No
Liver or Kidney transplant or disease	Yes / No	70 years or older	Yes / No

Your signature below indicates that the information above is correct. You have read and understand the above information and give MidAmerica Orthopaedics S.C. consent to perform the procedure.

_____

Signature **Date**