



MAGNETIC RESONANCE SCREENING FORM

Date \_\_\_/\_\_\_/\_\_\_ Name \_\_\_ Age \_\_\_ Weight \_\_\_ lbs MRN # \_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Area to be Imaged: \_\_\_ Reason for MRI and/or Symptoms \_\_\_

Have you ever: Yes No Are You: Yes
Been a Metal Worker?
Been hit in the eye or face with metal pieces?
Had metal removed from your eyes?
Do You Have Cancer? Type

Please describe any other tests (Xrays, US, CT, MRI), surgeries or procedures you have had performed on the a being imaged

When and where were these tests performed?

List any previous illness or operations involving the area being imaged today

Please indicate if you have / or ever had any of the following:

Cardiac Pacemaker
Implated Defibrillator (ICD)
Aneurysm Clip(s)
Electronic Implant or Device
Magnetically activated implant
Nerve or muscle stimulator (TENS)
Eye implant
Cochlear or other ear implant
Hearing aids
Tattoo eyeliner or body tattoo
Dentures, Braces or retainer
Jewelry / Body Piercing
Wire mesh implant
Bone joint pin, screw, rod, or plate
Diabetes Mellitus
History of Kidney Disease
Heart valve
Metallic stent, filter, or coil
Internal electrodes or wires
Implanted drug infusion device
Vascular access port and/or cath
Medication patch (nicotine, etc.)
Shunt (ventricular, spinal)
Surgical clips, wires, staples, or sutures
Metal fragments or shrapnel
Bullets, pellets, BB's
Penile implant
Diaphragm
Other intra-uterine device (IUD)
Any other implanted item
Artificial or prosthetic limb
List prescribed medications

If Yes, Describe

Warning: Certain implants, devices, or objects may be hazardous to you and/or interfere with the MR procedure. Do not enter the MRI system room or MR environment if you have any question or concern regarding an implant, device or obje Consult the MRI Technologist or Radiologist BEFORE entering the MRI system room. The MRI system magnet is ALWAYS on

Note: You will be required to wear earplugs during the MR procedure due to the acoustic noise.

Note: Please remove any jewelry including watches before your MR procedure.

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

Signature of person completing form: \_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Technologist Use Only

Pertinent Lab Values: BUN \_\_\_ Creatinine \_\_\_ GFR \_\_\_ Date of Labs \_\_\_
IV Access Venipuncture site: \_\_\_ Type Needle/Cath: \_\_\_ # Sticks
Existing IV Contrast amount: \_\_\_ Injected by: \_\_\_ Rate: \_\_\_

