MAGNETIC RESONANCE IMAGING (MRI) PROCEDURE SCREENING FORM FOR PATIENTS

Name _____ Date of Birth ____/____/_____

Age _____ Height _____ Weight _____ Male ☐ Female ☐ Today's Date ____/____/_____

Would you like us to fax the results to your primary care provider? ..... ☐ Yes ☐ No

If yes: Name: _____

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1. What was your main orthopedic complaint when you visited your doctor? _____

   _____

2. Have you had prior surgery or an operation of any kind? If yes, please indicate: _____ ☐ Yes ☐ No

   Date ____/____ Type of surgery _____

   Date ____/____ Type of surgery _____

   Date ____/____ Type of surgery _____

3. Have you ever had an injury to the eye involving a metal object or fragment? ☐ Yes ☐ No
   (I.e. metallic slivers, shavings, BB, bullet, shrapnel, etc.)? Was it removed? ☐ Yes ☐ No

4. Do you have any **<u>foreign</u>** metal objects or fragments in your body? ☐ Yes ☐ No
   If yes, please describe _____
   Was it removed? ☐ Yes ☐ No

5. Are you currently taking, or have recently taken any medication or drug? ☐ Yes ☐ No
   If yes, please list _____

   _____

6. Do you have a history of any of the following?
   ☐ High blood pressure ☐ Renal (kidney) disease, failure, or transplant ☐ None
   ☐ Diabetes ☐ Seizures

For female patients only:

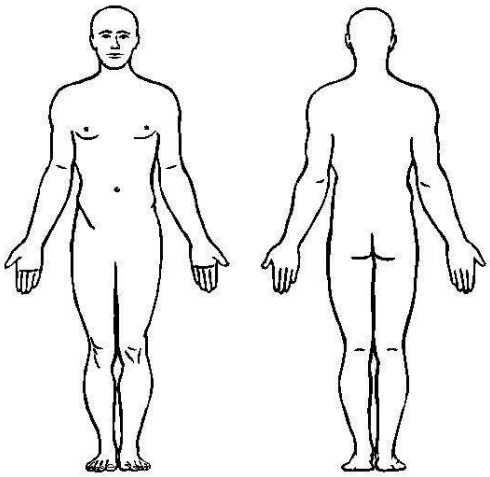
Are you pregnant or experiencing a late menstrual period? ☐ Yes ☐ No
Are you taking any type of fertility medication, or having fertility treatments? ☐ Yes ☐ No
Are you currently breastfeeding? ☐ Yes ☐ No

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

Please indicate if you have any of the following:

☐ Yes ☐ No Aneurysm clip(s)
☐ Yes ☐ No Cardiac pacemaker
☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
☐ Yes ☐ No Electronic implant or device
☐ Yes ☐ No Magnetically-activated implant or device
☐ Yes ☐ No Neurostimulation system
☐ Yes ☐ No Spinal cord stimulator
☐ Yes ☐ No Internal electrodes or wires
☐ Yes ☐ No Bone growth/bone fusion stimulator
☐ Yes ☐ No Cochlear, otologic, or other ear implant
☐ Yes ☐ No Insulin or other infusion pump
☐ Yes ☐ No Any prosthesis (i.e. eye, penile, etc.)
☐ Yes ☐ No Heart valve prosthesis
☐ Yes ☐ No Eyelid spring or wire
☐ Yes ☐ No Artificial or prosthetic limb
☐ Yes ☐ No Metallic stent, filter, or coil
☐ Yes ☐ No Shunt (spinal or intraventricular)
☐ Yes ☐ No Vascular access port and/or catheter
☐ Yes ☐ No Radiation seeds or implants
☐ Yes ☐ No Swan-Ganz or thermodilution catheter
☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
☐ Yes ☐ No Any metallic fragment or foreign body
☐ Yes ☐ No Wire mesh implant
☐ Yes ☐ No Tissue expander (i.e. breast)
☐ Yes ☐ No Surgical staples, clips, or metallic sutures
☐ Yes ☐ No Joint replacement (i.e. hip, knee, etc.)
☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc
☐ Yes ☐ No IUD, diaphragm, or pessary
☐ Yes ☐ No Dentures or partial plates
☐ Yes ☐ No Tattoo or permanent make-up
☐ Yes ☐ No Body piercings and jewelry
☐ Yes ☐ No Hearing aid *(Remove before entering MR room)*
☐ Yes ☐ No Other implant _____
☐ Yes ☐ No Breathing problem or motion disorder
☐ Yes ☐ No Claustrophobia

Please mark on the figures below, the location of any implant or metal in or on your body.



Important Instructions

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercings, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clippers, tools, clothing with metal fasteners and metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

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

Signature of person completing form _____ Date ____/____/_____
(Signature)

Form completed by ☐ Patient ☐ Relative ☐ Nurse _____ _____
(Print Name) (Relationship to patient)

Form information reviewed by _____ _____
(Print Name) (Signature)

☐ MRI Technologist ☐ Nurse ☐ Radiologist ☐ Other _____