



## MRI PATIENT SCREENING FORM

### Please answer the following Questions:

1. Do you have a **Pacemaker, Pacing Wires, ICD** ( Implantable Cardioverter Defibrillator) ☐ Yes ☐ No
2. Have you had an injury to the eye involving a metallic object or fragment (e.g. metallic sliver, shavings, foreign body, etc.), or worked with metal? ☐ Yes ☐ No  
*If yes, please describe:* \_\_\_\_\_
3. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast media or 'dye' used for an MRI, CT, or X-ray examination? ☐ Yes ☐ No  
*If yes, please list:* \_\_\_\_\_

### Please indicate if you have any of the following:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Brain Aneurysm Clip(s) – If Yes, Date of Surgery _____ Name of Hospital _____               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Brain surgery involving metal clips or implants – If Yes, Name of Hospital _____            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cardiac Pacemaker, Pacing Wires, Implanted Cardioverter Defibrillator (ICD)                 |                              |                             |
| Electronic implant or device – If Yes, what type _____                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Magnetically-activated implant or device – If Yes, where _____                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any metallic fragment or foreign body – If Yes, where _____                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neurostimulation system – If Yes, what type _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Spinal cord stimulator – If Yes, what type _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bone growth/bone fusion stimulator – If Yes, what type _____                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any type of prosthesis (eye, penile, etc.) – If Yes, where _____                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart valve prosthesis – If Yes, what type _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Metallic stent filter or coil – If Yes, what type _____                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Radiation seeds or implants – If Yes, where _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Wire mesh implant – If Yes, what type _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Surgical staples, clips or metallic sutures – If Yes, where _____                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Joint replacement (hip, knee, etc.) – If Yes, where _____                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bone/joint pin, screw, nail, wire, plate, etc – If Yes, where _____                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Internal electrodes or wires  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cochlear, otologic or other ear implant/surgery   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Implanted insulin or other drug infusion device or pump                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eyelid spring or wire   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial or prosthetic limb   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shunt (spinal or intraventricular)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vascular access port and/or catheter  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| AAA Endovascular Graft  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swan-Ganz or thermodilution catheter  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tissue expander (e.g., Breast)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Implants   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| IUD, diaphragm, or pessary  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dentures, partial plates, magnetic dental implant   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other implant _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Medication patch (Nicotine, Nitroglycerine) ( <b>Remove before entering MRI scan room</b> ) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hair Wig or Hair Extensions ( <b>MAY need to be Removed before entering MRI scan room</b> ) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Body piercing jewelry ( <b>Remove before entering MRI scan room</b> )                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hearing aid ( <b>Remove before entering MRI scan room</b> )                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tattoo or permanent makeup – If Yes, where _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breathing Problems or Motion disorder   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Claustrophobia or anxious   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### FOR FEMALE PATIENTS:

4. Date of last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_ Post Menopausal? ☐ Yes ☐ No
5. Are you pregnant? ☐ Yes ☐ No
6. Are you experiencing a late menstrual period? ☐ Yes ☐ No
7. Are you taking oral contraceptives or receiving hormonal treatment? ☐ Yes ☐ No
8. Are you taking any type of fertility medication or having fertility treatments? ☐ Yes ☐ No  
*If yes, please describe:* \_\_\_\_\_
9. Are you currently breast-feeding? ☐ Yes ☐ No



## MRI PATIENT SCREENING FORM

### Kidney/Liver Function Questions

Are you currently on dialysis?

☐ Yes ☐ No

If Yes, when is your next dialysis? \_\_\_\_\_

Do you have any of the following conditions? **If yes please check each**

☐ Yes ☐ No

☐ Kidney disease

☐ Diabetes: managed with medications

☐ Family history of kidney failure(polycystic)

☐ Multiple myeloma

☐ Lupus

☐ Chronic liver disease

### Medication Questions

1 Have you taken any nonsteroidal anti-inflammatory drugs(NSAIDS)

☐ Yes ☐ No

e.g., Aleve/Anaprox.Naprosyn (Naproxen), Celebrex (celecoxib), Motrin/Advil (ibuprofen), Indocin/Indomethacin within the last 24 hours.

If yes, have you taken this/these medication(s) for 4 consecutive days?

☐ Yes ☐ No

2. Have you taken any of the following antibiotics intravenously for 2 or more days?

☐ Yes ☐ No

☐ Amikacin ☐ Gentamicin ☐ Tobramycin ☐ Vancomycin

3. Have you taken the antifungal drug Amphotericin B (not including Ambisome) intravenously for 2 days or more?

☐ Yes ☐ No

4. Have you taken the chemotherapy drug Methotrexate within the past 3 days?

☐ Yes ☐ No

5. Have you taken the chemotherapy drug Cisplatin within the past 3 weeks?

☐ Yes ☐ No

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 MRI procedure that I am about to undergo.

Signature of Person Completing Form: \_\_\_\_\_

Date \_\_\_\_\_

Form Completed By: ☐ Patient ☐ Nurse \_\_\_\_\_

Print Name

☐ Relative \_\_\_\_\_

Relationship to Patient

### **MRI Staff Use**

Form Information Reviewed By: \_\_\_\_\_

Print Name

MRI Technologist Signature

IV Inserted by: \_\_\_\_\_ IV Gauge/type \_\_\_\_\_ ☐ Left ☐ Right \_\_\_\_\_ Scanned By \_\_\_\_\_

Type of Contrast \_\_\_\_\_ Amount \_\_\_\_\_ Lot Number \_\_\_\_\_ Exp. Date \_\_\_\_\_

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4