ADVANCED OPEN IMAGING
MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date: ____/____/____
Name: _____ Age: _____ Height: _____ Weight: _____
Date of Birth: ____/____/____ Sex: _____ Body part being scanned: _____
Reason for MRI and/or Symptoms: _____
Referring Physician: _____

THE FOLLOWING ITEMS MAY BE HARMFUL TO YOU DURING YOUR MR SCAN OR MAY INTERFERE WITH THE MR EXAMINATION.
You must provide a Yes or No for every item. Yes to some items may result in the inability to perform your MRI or will require additional time for our staff to obtain operative reports to insure your safety. Please indicate if you have or have had any of the following:

YES NO

____ ____ Cardiac pacemaker
____ ____ Implanted cardiac defibrillator
____ ____ Any type of internal electrode(s) or wire(s)
____ ____ Aneurysm clip(s)
____ ____ Metal in eye (or possibility of metal in eye)
____ ____ Cochlear implant or any other type of ear implant
____ ____ Eyelid spring, retinal tack or artificial eye
____ ____ Any type of electronic, mechanical, or magnetic implant. (Type_____)
____ ____ Any type of implant held in place by a magnet (Type_____)
____ ____ Implanted drug pump (e.g., insulin, Baclofen, chemotherapy, pain medicine)
_____ ____ Neurostimulator or biostimulator (Where _____)
_____ ____ Spinal cord stimulator
____ ____ Bone growth/bone fusion stimulator (Type_____)
____ ____ Any implanted items (e.g., pins, rods, screws, nails, plates, wires)
____ ____ Surgical clips, staples or metallic sutures (Where _____)
____ ____ Any type of coil, filter, or stent (Type_____)
____ ____ Artificial heart valve
____ ____ Shunt (spinal or intraventricular)
____ ____ Halo vest
____ ____ Spinal fixation device or spinal fusion procedure
____ ____ Artificial limb or joint (What and where_____)
____ ____ Wire mesh (Location_____)
____ ____ Tissue expander (e.g., breast)
____ ____ Diaphragm, IUD, Pessary (Type_____)
____ ____ Penile implant
____ ____ Any I.V. access port (e.g., Broviac, Port-a-Cath, Hickman, Picc line)
____ ____ Medication patch (e.g., Nitroglycerine, nicotine)
____ ____ Radiation seeds (e.g., cancer treatment)
____ ____ Any other type of implanted item (Type_____)
____ ____ Any type of metal object (e.g., shrapnel, bullet, BB)
____ ____ Removable dentures, false teeth or partial plate
____ ____ Hearing aid *(remove before entering MR system room)*
____ ____ Jewelry or any body piercing (Location of piercing/s_____)
____ ____ Wig, hair implants or any hair accessories (bobby pins, barrettes, clips)
____ ____ Tattoos or permanent makeup
____ ____ Breathing problem, motion disorder or claustrophobia

YES NO

____ ____Have you had an injury related to your current problem?
If yes, please indicate date and type of injury: _____

____ ____ Have you had prior surgery or an operation (e.g. arthroscopy, endoscopy, etc.) of any kind?
If yes, please indicate the date and type of surgery:
Date: ____/____/____ Type of surgery: _____
Date: ____/____/____ Type of surgery: _____

____ ____ Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)?
If yes, please list body part/date/facility: _____
_____

____ ____ Have you experienced any problem related to a previous MRI examination?
If yes, please describe: _____

____ ____ Are you currently taking or have you recently taken any medication or drug?
If yes, please list: _____

____ ____ Are you allergic to any medications?
If yes, please describe: _____

For female patients:

Date of last menstrual period: ____/____/____ Post menopausal? Yes No

____ ____ Are you pregnant, think you might be pregnant or experiencing a late menstrual period?

____ ____ Are you currently breastfeeding?

IMPORTANT INSTRUCTIONS FOR ALL PATIENTS:

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 piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners and clothing with metallic threads.

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

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

Signature of Person Completing Form: _____ Date: _____

Form Completed By: _____ _____
print name *relationship to patient*

Form Information Reviewed By: _____ _____
print name/title *signature*