MAGNETIC RESONANCE (MR) PATIENT SCREENING FORM

WARNING: THE MR SYSTEM MAGNET IS ALWAYS ON! If exposed to the magnetic field, certain implants, medical devices or objects in or on your body may become hazardous to you, may malfunction or may interfere with the ordered MR procedure. DO NOT ENTER the MR environment if you have any concern regarding an implant, device or object.

Name _____ DOB_____/_____/_____ MR#_____
Last name First name Middle Initial

Medical Allergies: _____ Weight _____lbs_/_____kgs

Type of reaction: _____Referring MD: _____

Breast Implants? N__ Y__ If *yes*, circle type**: Right**: silicone saline **Left**: silicone saline
Are you or could you be pregnant? N__ Y__ *First date* of last menstrual period: ___/___/___ or Post-Menopausal N__Y__

Do you have any kidney (renal) or liver (hepatic) problems? N__Y__ *If Yes, please explain:* _____ *GFR*____

Have you ever had X-ray dye/iodinated contrast? Yes___ No___
Have you ever had a reaction to the dye/contrast? Yes___ No___
If yes, describe: _____

Have you had an MRI examination before? Yes___ No___

Body part	Date	Facility
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____

Have you ever had MRI contrast/***Gadolinium***? Yes___ No___
Have you ever had a reaction to the MRI contrast/***Gadolinium***? Yes___ No___
If yes, describe: _____

Have you had prior surgery or an operation of any kind ***in the last 8 weeks***? Yes___ No___
If yes, please indicate the date and type of surgery:
Date _____/_____/_____ Type of surgery _____
Date _____/_____/_____ Type of surgery _____

Have you had an injury to the eye involving a metallic object or fragment? Yes___ No ___
(metallic slivers, shavings, foreign body, etc.)?
If yes, please describe: _____

Have you ever been injured by a metallic object or foreign body (BB, bullet, shrapnel, etc.)? Yes___ No___
If yes, please describe: _____

Are you taking oral contraceptives or receiving hormonal treatment? Yes___ No___
Are you taking any type of fertility medication or having fertility treatments? Yes___ No___
If yes, please describe: _____

Are you currently breastfeeding? Yes___ No___

Please circle Yes or No if you have the following:

Aneurysm clip	Yes	No	Dental implants	Yes	No
Cardiac pacemaker	Yes	No	Dentures/removal dental work	Yes	No
Hearing aids	Yes	No	Neurostimulator device	Yes	No
Implanted cardiac defibrillator	Yes	No	Medication patch	Yes	No
Implanted epicardial pacemeaker leads	Yes	No	Tatoo/permanent makeup	Yes	No
Prosthetic heart valve or replacement	Yes	No	Body piercing	Yes	No
Implanted insulin or chemotherapy pump	Yes	No	Prosthesis (eye, limb)	Yes	No
Electronic or magnetically activated implant /device	Yes	No	IUD, pessary, diaphragm	Yes	No
Cochlear implant	Yes	No	Tissue expander/implant spacer	Yes	No
Shunt (spinal,ventricular)	Yes	No	Orthopedic hardware	Yes	No
Metallic stent, filter or coil	Yes	No	Harrington rods	Yes	No
Vascular access port or catheter	Yes	No			
Are you:			**Do you have:**		
Taking blood thinners or aspirin?	Yes	No	Seizure disorder	Yes	No
Taking Tamoxifen/Arimidex/Femara?	Yes	No	Involuntary movement disorder	Yes	No
Claustrophobic	Yes	No	Asthma	Yes	No

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

Signature of patient or person completing form: _____ Date:_____
Relationship to patient:_____
Witness/Technologist: _____ Reviewed & Approved by:_____M.D.Date: _____