The Joint Department of MEDICAL IMAGING

MAGNETIC RESONANCE IMAGING
SCREENING FORM

Patient Name & MRN / Label_____

This form **must** be reviewed by the MRI Technologist, with the patient or Substitute Decision Maker, prior to the patient entering the MRI scan room, for every appointment.

Patient Instructions
Before your MRI scan, you must remove **all** metallic objects including hearing aids, keys, pagers, cell phones, hair pins, jewelry, body piercing jewelry, watch, safety pins, magnetic strip cards, pens, coins etc. You will be asked to change into hospital supplied MRI approved clothing, as any street clothing and metal may not be safe to be worn in the MRI room. Glasses, dentures, partial plates, wigs/hairpieces and hearing aids will be removed closer to the MRI room.

Please answer the following questions on both sides of this sheet:

1. Have you had a previous MRI?	❑ Yes	❑ No
a) Did you have an injection of MRI contrast (dye)?	❑ Yes	❑ No
b) Were there any problems from the injection of MRI contrast (dye)?	❑ Yes	❑ No
2. Do you have drug / medication allergies?	❑ Yes	❑ No
Please list allergies _____		
3. Do you have any kidney disease?	❑ Yes	❑ No
4. Are you on dialysis?	❑ Yes	❑ No
5. Do you have diabetes?	❑ Yes	❑ No
6. Have you ever had metal in your eyes from any accidents, welding, grinding etc.?	❑ Yes	❑ No
7. Are you pregnant, experiencing a late menstrual period, or having fertility treatments?	❑ Yes	❑ No
8. Are you currently breastfeeding?	❑ Yes	❑ No
9. Have you taken a sedative for the MRI exam today?	❑ Yes	❑ No
a) If yes, do you have someone to drive you home?	❑ Yes	❑ No
b) If yes, please indicate who is driving you home. _____		
10. Mobility: Are you unsteady on your feet or had any falls in the last year?	❑ Yes	❑ No
11. Are you currently taking aspirin or blood thinners?	❑ Yes	❑ No
12. Have you previously taken or are currently taking Feraheme (ferumoxytol)?	❑ Yes	❑ No
13. Are you taking PolyMVA dietary supplements (polydox, LAPd, Palladium)?	❑ Yes	❑ No
14. Are you wearing any clothing with Copper, Silver, or other metallic fibers/threads?	❑ Yes	❑ No
15. Do you have wound care with Silver Dressings or Silver Powder?	❑ Yes	❑ No
16. Do you have asthma or breathing disorders?	❑ Yes	❑ No
17. Do you have seizures or motion disorders?	❑ Yes	❑ No

Your Weight_____ Your Height_____

Please list ALL surgeries/ procedures you may have had to your:

Head:_____ Abdomen/Pelvis:_____

Neck:_____ Chest:_____

Spine:_____ Arms/Legs:_____

Turn Over

Have you ever had any of the following:			Please Clarify/Identify:
Implanted cardiac Pacemaker /Defibrillator	❑ Yes	❑ No	
Heart valve prosthesis	❑ Yes	❑ No	
Internal pacing wires	❑ Yes	❑ No	
Neurostimulator	❑ Yes	❑ No	
Spinal or Bone fusion stimulator	❑ Yes	❑ No	
Aneurysm clip (intracranial) or brain clip	❑ Yes	❑ No	
Cochlear, otologic, or ear implant	❑ Yes	❑ No	
Carotid artery vascular clamp	❑ Yes	❑ No	
Vascular access ports or catheters	❑ Yes	❑ No	
Surgical mesh	❑ Yes	❑ No	
Stents, filters, coils (e.g. coronary, aorta)	❑ Yes	❑ No	
Swan-Ganz catheter(pulmonary artery line)	❑ Yes	❑ No	
Insulin or other implanted drug infusion pump	❑ Yes	❑ No	
Tissue expander (breast, head)	❑ Yes	❑ No	
Prosthesis (penile, eye, ear, etc.)	❑ Yes	❑ No	
Artificial limb or joint	❑ Yes	❑ No	
IUD or diaphragm	❑ Yes	❑ No	
Pessary or bladder ring	❑ Yes	❑ No	
Menstrual/moon cup ***(may remove before scan)***	❑ Yes	❑ No	
Eyelid spring or wire	❑ Yes	❑ No	
Wire sutures or surgical staples, clips	❑ Yes	❑ No	
Shunt (spinal or intraventricular) programmable?	❑ Yes	❑ No	
Shrapnel, buckshot, or bullets	❑ Yes	❑ No	
Implant held in place by a magnet	❑ Yes	❑ No	
Other implants in body (e.g. radiation seeds)	❑ Yes	❑ No	
Body piercing(s) ***(remove before scan)***	❑ Yes	❑ No	
Tattoos, permanent makeup	❑ Yes	❑ No	
Medication patch ***(may remove before scan)***	❑ Yes	❑ No	
Wig, toupee ***(remove before scan)***	❑ Yes	❑ No	
Hearing aid ***(remove before scan)***	❑ Yes	❑ No	
Dentures ***(may remove before scan)***	❑ Yes	❑ No	
Anything else not listed?	❑ Yes	❑ No	

Form Completed By: Patient ❑ Relative/Other /SDM ❑

Name _____

Relationship to Patient _____

Patient Signature (or Substitute Decision Maker) _____

Interpreter Name/ ID Number _____

Interpretation Assistance comments (relationship & language) _____

Form Reviewed by:

MRI Technologist ❑ MRI Radiologist/Physician ❑

Name: _____ Signature: _____

Technologist to complete: OK for 3T ❑ OK for contrast ❑ eGFR comments _____

Date: _____