## Magnetic Resonance (MR) Procedure Screening

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Age: _____ Height: _____ Weight: _____ ☐ Male ☐ Female

Body Part to be examined: _____

Reason for MRI and/or Symptoms: _____

Referring Provider: _____ Telephone: _____

1. Have you had prior surgery or an operation on the area we are scanning today? ☐ No ☐ Yes
   If yes, please indicate the date and type of surgery:

| Date | Type of Surgery |
|---|---|
| | |
| | |

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ☐ No ☐ Yes
   If yes, please list:

| Exam Type | Body part | Date | Facility |
|---|---|---|---|
| MRI | | | |
| CT Scan | | | |
| X-Ray | | | |
| Ultrasound | | | |
| Nuclear Medicine | | | |
| Other: _____ | | | |

3. Have you experienced any problems related to a previous MRI examination or MR procedure? ☐ No ☐ Yes
   If yes, please describe: _____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ No ☐ Yes
   If yes, please describe: _____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.? ☐ No ☐ Yes
   If yes, please describe: _____
6. Are you currently taking or have you recently taken any medication or drug? ☐ No ☐ Yes
   If yes, please list: _____
7. Are you allergic to any medication? ☐ No ☐ Yes
   If yes, please list: _____
8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for MRI, CT, or X-ray examination? ☐ No ☐ Yes
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? ☐ No ☐ Yes
   If yes, please describe: _____

**For Female Patients:**

10. Date of last menstrual period: _____ ☐ No ☐ Yes
11. Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ☐ No ☐ Yes
13. Are you taking any type of fertility medication or having fertility treatments? ☐ No ☐ Yes
    If yes, please describe: _____
14. Are you currently breast feeding? ☐ No ☐ Yes

South Peninsula Hospital

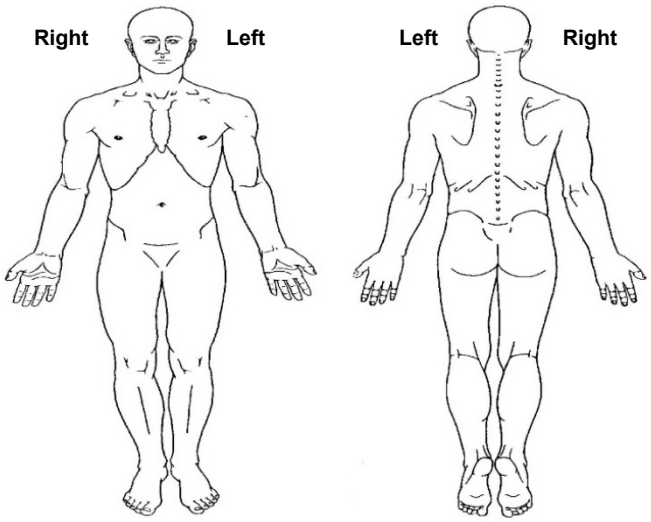
Patient Label

**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 MR 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 Implanted drug infusion device
☐ Yes ☐ No Any type of prosthesis (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 (e.g., breast)
☐ Yes ☐ No Surgical staples, clips, or metallic sutures
☐ Yes ☐ No Joint replacement (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 makeup
☐ Yes ☐ No Body piercing jewelry
☐ Yes ☐ No Hearing aid
(*Remove before entering MR system room)*
☐ Yes ☐ No Other Implant:
_____
☐ Yes ☐ No Breathing problem or motion disorder

**Please mark on drawing area of pain. Draw arrows if pain extends from one area to another.**




## 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 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, & 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.**

***NOTE: You will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise. You will be required to change into hospital-issued scrubs before the exam.***

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 am about to undergo.

| | Patient/Representative: | Professional Witness: | Procedural Clinician: |
|---|---|---|---|
| Printed Name: | _____ | _____ | _____ |
| Signature: | _____ | _____ | _____ |
| Date/Time | _____/_____ | _____/_____ | _____/_____ |

Relation to Patient: _____