

MRI PATIENT SCREENING FORM

PATIENT & APPOINTMENT INFORMATION

NAME: _____ DATE OF SERVICE: _____
 DOB: _____ AGE: _____
 PHYSICIAN: _____ EXAM (REASON): _____
 FACILITY: _____

PATIENT & INJURY INFORMATION

HEIGHT: _____ WEIGHT: _____
 IS TODAY'S VISIT DUE TO AN INJURY? Yes No IF YES, DATE OF INJURY: _____
 SPORTS INJURY? Yes No MOTOR VEHICLE? Yes No WORK INJURY? Yes No
 WORKERS COMP CLAIM #: _____
 DESCRIBE YOUR SYMPTOMS: _____

HAVE YOU HAD A PREVIOUS MRI, CT or X-RAY RELATED TO THIS VISIT? Yes No
 IF YES, WHEN and WHERE? _____

PLEASE CHECK ALL THE OPTIONS IN THIS SECTION WHICH APPLY OR MAY APPLY TO THE PATIENT

Please indicate whether each of the following applies to the patient. If the answer is yes to any of the following the MRI **CANNOT BE DONE**:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Implanted insulin or medication pump | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Implanted neuro-stimulator (tens) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Defibrillator | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Magnetic dental implants | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Magnetic artificial eye | <input type="checkbox"/> | <input type="checkbox"/> |

Please indicate whether each of the following applies to the patient.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Previous spine surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Heart bypass surgery (6 weeks post) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Cataract surgery (6 weeks post) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Gallbladder surgery (6 weeks post) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Joint replacement/orthopedic hardware | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Body piercing | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Dentures | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Hearing aids | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Breast feeding | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Latex allergies / risk for latex allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Claustrophobic | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Transdermal patch medication and/or nicotine | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Itching, hives, running nose, eye irritation, wheezing after contact with rubber products?
<i>Examples: rubber gloves, balloons, diaphragms or condoms</i> | <input type="checkbox"/> | <input type="checkbox"/> |

Please indicate whether each of the following applies to the patient. If the answer is yes to any of the following the MRI **MAY NEED TO BE** discussed with the Radiologist first: *(Manufacturer, model and make of any implanted devices must be known)*

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Brain surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Brain aneurysm clips | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Inner ear implant | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Pregnant or may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Retina repair clips | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Heart valve | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Implanted shunts or ports | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Penile implants | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Shrapnel or other metal particles | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Metal grinding/welding without eye protection | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Tattooed eyeliner | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Previous reaction to (MRI) contrast | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Kidney disease, single kidney | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Currently on dialysis | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Diabetic | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Chronic high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Sickle cell anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Multiple myeloma | <input type="checkbox"/> | <input type="checkbox"/> |

 Patient Signature Date

 Technologist Signature Date