MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

<table>
<thead>
<tr>
<th>Date</th>
<th>/ /</th>
<th>Patient Number</th>
<th>________________________________</th>
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<tbody>
<tr>
<td>Name</td>
<td></td>
<td>Age</td>
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Date of Birth / / / Male Female Body Part to be examined ________________________________

Reason for MRI and/or Symptoms _______________________________________________________

Referring Physician _________________________________________________________________

| 1. | Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? No Yes |
|    | If yes, please indicate the date and type of surgery: | | |
|    | Date / / / | Type of Surgery | |
|    | Date / / / | Type of Surgery | |

| 2. | Have you experienced any problem related to a previous MRI examination or MR procedure? If No Yes |
|    | yes, please describe: | |

| 3. | Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, No Yes |
|    | shavings, foreign body, etc.)? | |
|    | If yes, please describe: | |

| 4. | Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? No Yes |
|    | If yes, please describe: | |

| 5. | Are you allergic to any medication? If No Yes |
|    | yes, please list: | |

| 6. | Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast No Yes |
|    | medium or dye used for an MRI, CT, or X-ray examination? | |

| 7. | Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) No Yes |
|    | disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), | |
|    | liver (hepatic) disease, a history of diabetes, or seizures? | |
|    | If yes, please describe: | |

For female patients:

| 8. | Date of last menstrual period: / / / | Post menopausal? No Yes |
|    | | |

| 9. | Are you pregnant or experiencing a late menstrual period? No Yes |

| 10. | Are you currently breastfeeding? No Yes |
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 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
- Yes No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.

**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 if you have any question or concern BEFORE you enter the MR system room.

NOTE: You will be advised to wear earplugs during the MR procedure to reduce acoustic noise related to the MRI procedure.

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.

Signature of Person Completing Form: ________________________________ Date ___/___/____

Signature

Form Completed By: O Patient  O Relative  O Nurse ________________________________ Relationship to patient

Print name

Form Information Reviewed By: ________________________________

Print name Signature

O MRI Technologist
The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. Therefore, all individuals are required to fill out this form BEFORE entering the MR environment or MR system room. Be advised, the MR system magnet is ALWAYS on.

*NOTE: If you are a patient preparing to undergo an MR examination, you are required to fill out a different form.

Date _____/_____/____  Name ___________________________________________________

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?  □ No □ Yes
   If yes, please indicate date and type of surgery: Date _____/_____/_____  Type of surgery________________________

2. Have you had an injury to the eye involving a metallic object (e.g., metallic slivers, foreign body)?  □ No □ Yes
   If yes, please describe: _______________________________________________________________

3. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?  □ No □ Yes
   If yes, please describe: _______________________________________________________________

4. Are you pregnant or suspect that you are pregnant?  □ No □ Yes

WARNING: Certain implants, devices, or objects may be hazardous to you in the MR environment or MR system room. Do not enter the MR environment or MR system room if you have any question or concern regarding an implant, device, or object.

Please indicate if you have any of the following:

□ Yes □ No Aneurysm clip(s)
□ Yes □ No Cardiac pacemaker
□ Yes □ No Implantable 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 Cochlear implant or implanted hearing aid
□ Yes □ No Insulin or infusion pump
□ Yes □ No Implanted drug infusion device
□ Yes □ No Any type of prosthesis or implant
□ Yes □ No Artificial or prosthetic limb
□ Yes □ No Any metallic fragment or foreign body
□ Yes □ No Any external or internal metallic object
□ Yes □ No Hearing aid
□ Yes □ No Other implant______________________
□ Yes □ No Other device_____________________

IMPORTANT INSTRUCTIONS

Remove all metallic objects before entering the MR environment or MR system room including hearing aids, beeper, cell phone, keys, eyeglasses, hair pins, barrettes, jewelry (including body piercing jewelry), watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, steel-toed boots/shoes, and tools. Loose metallic objects are especially prohibited in the MR system room and MR environment.

Please consult the MRI Technologist 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 entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature of Person Completing Form: ___________________________________________ Date _____/_____/_____  

Form Information Reviewed By: ___________________________________________ Print name ____________________________  Signature ____________________________

□ MRI Technologist