



Magnetic Resonance Imaging (MRI) Screening Form

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Age: _____ Height: _____ Weight: _____ Date of Birth (MM/DD/YY): _____ Male Female Other

Body part to be examined: _____

Reason for MRI and/or symptoms:

Have you had prior surgery or an operation **on this body part** of any kind? Yes No

If yes, please indicate the date and type of surgery:

Date: _____ Type of Surgery: _____

Date: _____ Type of Surgery: _____

Have you had a prior diagnostic imaging study (MRI, CT, Ultrasound, X-Ray, etc.) **on this body part**?

Yes No

If yes, please list:

MRI Body Part: _____ Date: _____ Facility: _____

CT/CAT Scan Body Part: _____ Date: _____ Facility: _____

X-Ray Body Part: _____ Date: _____ Facility: _____

Ultrasound Body Part: _____ Date: _____ Facility: _____

Nuclear Medicine Body Part: _____ Date: _____ Facility: _____

Other Body Part: _____ Date: _____ Facility: _____

Have you experienced any problem related to a previous MRI examination or MR procedure? Yes No

If yes, please describe: _____

Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)?

Yes No

If yes, please describe: _____

Are you allergic to any medication? Yes No

If yes, please list:

Do you have a history of asthma, allergic reaction, respiratory disease or reaction to a contrast medium used for MRI?

Yes No

For female patients: Are you pregnant or suspect that you might be pregnant? Yes No



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/device
- Yes No Neurostimulation system
- Yes No Metallic stent, filter or coil
- Yes No Shunt (spinal or intraventricular)
- 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 pump, CGM or infusion device
- 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 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
- Yes No Claustrophobia



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plate, keys, 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, and 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 may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

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.

I authorize the release of any medical information, including prior xrays, to be released to Hope Orthopedics of Oregon or Radsorce to be used in the continuum of my medical care:

Patient Signature: _____ Date: _____

If patient is a minor, the parent/guardian: _____ Date: _____

OFFICE USE:

Form information reviewed by: _____ Date: _____