LAKE POINTE
HEALTH NETWORK

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____/_____/_____ Patient Number ___________________________

Name _______________________________________ Age _______ Height _______ Weight _______
Last name First name Middle Initial

Date of Birth _____/_____/_____ Male ❑ Female ❑ Body Part to be Examined ___________________

Reason for MRI and / or symptoms ____

1. Have you had prior surgery or an operation on the body part undergoing an MRI today? No ❑ Yes ❑
If yes, please indicate the date and type of surgery: (If you have had a pacemaker inserted please stop and notify staff immediately)
Date _____/_____/_____ Type of surgery ______________________________
Date _____/_____/_____ Type of surgery ______________________________

2. Have you had a prior diagnostic imaging study or examination on the body part being examined today? No ❑ Yes ❑

If yes, please list:	Body Part	Date	Facility
MRI	______________	______/______/______	______________
CT/CAT Scan	______________	______/______/______	______________
X-Ray	______________	______/______/______	______________
Ultrasound	______________	______/______/______	______________
Nuclear Medicine	______________	______/______/______	______________
Other	______________	______/______/______	______________

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

4. Have you ever worked in a field such as welding or other related industry where metal shavings and or shrapnel could have infiltrated your body (eyes, etc.)? No ❑ Yes ❑

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. List any medications you are presently taking, the dose, how often the medication is taken, and the last time it was taken:
____
____
____

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 an 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 or seizures? No ❑ Yes ❑
If yes, please describe: ______________________________

For female patients:

10. Date of last menstrual period: ______/______/______ Post menopausal 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 breastfeeding? No ❑ Yes ❑

Reserved For Hospital Use

The patient was informed to withhold ______________________________ for 48 hours post procedure.

Technologist Signature: ______________________________ Date ______________ Time ____________

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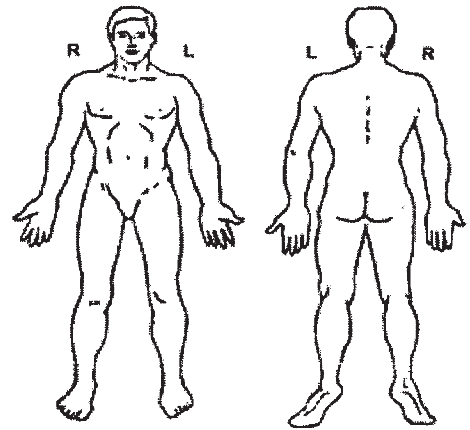
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e. MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. 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
❍ Yes ❍ No Claustrophobia

Please mark or color in on the figure(s) below indicating the area of pain/discomfort and or symptomatic area.



⚠ 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 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.

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

Form Completed By: ❑ Patient ❑ Relative ❑ Nurse ______________________________
Print name Relationship to Patient

Form Information Reviewed By: ______________________ ______________________
Print name Signature

❑ MRI Technologist ❑ Nurse ❑ Radiologist ❑ Other

MRI SCREENING FORM EN

Revised 8/13/12