MRI PATIENT SCREENING

Language Pref: English or Other: _____ Interpreter: Y N 2 Forms of ID: _____

DOB Verified: _____ Date Scheduled: _____ Initials: _____

Patient Name:	
Date of Birth:	Weight:
Area to Be Scanned:	

PATIENT LABEL

STOP! NO PACEMAKERS ALLOWED.

YES	NO	Check YES or NO for each of the following:
		Pacemaker - Internal Electrodes/Wires
		Kidneys Disease/Dialysis/Failure/Transplant
		Diabetes - Sensor/Transmitter/Pump
		Cardiac Defibrillator
		Neurostimulator/Biostimulator
		Aneurysm Clips
		Artificial Heart Valve
		Prior Heart Surgery
		Coils/Filters/Stents
		Tissue Expanders (Breast)
		Shunt
		Electrical/Mechanical/Magnetic Implants
		Drug Pump-Implanted/Non-Implanted
		Surgical Clips/Staples/Mesh/Stomach Band
		Penile Implant
		Radiation Seeds
		Bone/Joint Surgery (Pins, Screws, Plates)
		Artificial Limb/Joint
		Spine Surgery (Fusion, Rods)
		Prior Ear Surgery
		Ear Implants (Cochlear, Staples)
		Hearing Aids
		Prior Eye Surgery
		Artificial Eye, Eyelid Spring or Magnetic Eyelashes
		Prior Metal in Eyes
		Metal Fragments in Body
		Shrapnel/Bullet/BB
		IV Access Port
		Medication Patch
		Nail Polish
		Birth Control Implants (IUD, Diaphragm, etc.)
		Pregnant - LMP _____
		Breast Feeding
		Tattoos or Tattooed Make-Up
		Dentures/Partials
		Jewelry - Body Piercing

YES	NO	Check YES or NO for each of the following:
		Wig/Hair Implants/Hair Accessories
		Claustrophobic - Difficulty in Small Places
		Previous Surgery - If Yes, List Below:
		Head
		Neck
		Chest
		Abdomen
		Arms/Legs
		Previous CT/MRI of Area Being Scanned?
		Where?
		When?
		Previous X-rays of Area Being Scanned?
		Where?
		When?
		Previous Injury to Area Being Scanned?
		Where?
		When?
		Personal History of Cancer?
		Where?
		When?
		Allergies or Sensitivities?
		List:
		Previous CT/MRI Contrast?

CONTRAST	
Brand Name:	Time of Injection: am/pm
Lot #/Exp. Date:	
Dose:	Rate of Injection:
Injection Site/Needle:	
Creatinine:	GFR:
Power Injector: YES NO	
Difficulties Following Injection?	

List Current Medications:
List Clinical History:
Was a Handheld Metal Detector Used? YES NO (Technologist Initials)

Patient or Legal Guardian Signature _____ Date _____

Print Legal Guardian Name _____ Technologist Signature _____

Interpreters Name _____

SHARED MEDICAL SERVICES