Chinese

INPATIENT MRI SCREENING
住院病人做 核磁共振前问卷

Patient or family member PRIOR to the MRI exam MUST fill out form completely.
病人或家属在照核磁共振前必须填妥此表格

FAX back to MRI 598-8630 when completed. Call 598-4862 with questions.

Name 姓名_____Date of Birth:生日_____Weight 体重:___Height 身高:____

Do you have any allergies? (Y/N) 有无任何过敏？(Y 有/N 无)_____

If Yes, Please list them 如有、请列出:_____

The following items can interfere with MR imaging and some can actually be hazardous to your safety. Please check YES or NO if you have any of the following items: 下列物件会影响核磁共振的造影且危害您的安全。请勾选有、无下列物件:

YES 有	NO 无	
☐	☐	Have you ever had a MRI scan? 您曾经做过核磁共振吗？
☐	☐	Cardiac pacemaker or defibrillator 心脏起搏器或除颤器
☐	☐	Aneurysm clips in brain 脑部动脉瘤夹
☐	☐	Neurostimulator (TENS Unit) 神经刺激器 or insulin pump 或胰岛素泵 or Intrathecal pain pump 或鞘内注射止痛的泵
☐	☐	Vascular clip or intravascular filter, coil or stent, or swan ganz 血管夹或血管内过滤器、 盘管或支架、天鹅甘兹
☐	☐	Do you have any shunts? 您有装置任何分流导管吗？
☐	☐	Artificial heart valves 人工心瓣膜
☐	☐	Breast tissue expander 隆乳
☐	☐	Any ear implants/Hearing aids 任何耳内植入物/助听器
☐	☐	Any eye implants 任何眼内植入物
☐	☐	Tattoo eyeliner 纹眼线
☐	☐	Any orthopedic items (i.e. pins, rods, screws, nails, wires, or plates) 骨科植入物件（如：针、 杆、 螺钉、 钉、 铁线或板片）
☐	☐	Any surgical clips, wire sutures, or surgical staples 任何外科夹, 缝合之金属线或外科钉针

PT.NO

NAME

DOB

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Seattle, Washington

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☐ ☐ Prosthesis or artificial limb or joint replacement 假体或义肢或关节置换

☐ ☐ Dentures 假牙

☐ ☐ Nitroglycerin or Nicotine patches 硝化甘油或尼古丁贴片

☐ ☐ Penile Implant or IUD or diaphragm 阴茎植入或子宫环或子宫帽

☐ ☐ Have you ever in your lifetime been a metal worker, grinder, welder, machinist, etc., as a hobby or profession? 您一生以来曾否做过金属工人、 磨床、焊工、 钳工等？不伦是爱好或专业？

☐ ☐ Do you have any pieces of metal in your eyes? 您眼内有无任何金属片？

☐ ☐ Are you allergic to MRI contrast? 您是否对核磁共振的显影剂过敏？

☐ ☐ Are you on medication for diabetes ☐您是否在使用糖尿病的药物☐ and/or high blood pressure ☐及/或高血压的药物

☐ ☐ Do you have kidney disease, impairment, decreased renal function or on dialysis? 您有肾脏 病、肾损伤、肾功能减退或接受肾透析?

☐ ☐ Do you have a history of liver disease, liver transplant, or pending a liver transplant? 您过去有过 肝病、肝移植/或正等待肝移植？

☐ ☐ Any metallic body such as shrapnel, gunshot wound or BB pellet 体内有无任何金属弹片、枪伤、 BB 枪弹珠

☐ ☐ Are you nursing an infant? 您在哺母乳吗？

☐ ☐ Are you pregnant or do you suspect that you could be pregnant? 您正怀孕吗或您认为您可能已 怀孕？

☐ ☐ Will you need medication for pain ？☐您需要止痛药吗? and/or claustrophobia ☐及/或有幽闭恐惧症

☐ ☐ Have you ever had surgery 您曾经作过手术吗? If so, when and what type? 如有、是何时？何种手术？_____

Please describe your symptoms and how long they have been present 请叙述您的症状及此症状出现多久:

_____

Do you have any other pertinent medical problems 您还有其他的疾病吗?_____

_____

PATIENT SIGNATURE 病人签名		DATE 日期	FORM REVIEWED BY
WITNESS/RELATIONSHIP 证人/关系	PRINT NAME 姓名正楷		DATE 日期

PT.NO

NAME

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BACK