INPATIENT MRI SCREENING

Patient or family member PRIOR to the MRI exam MUST fill out form completely.
FAX back to MRI 598-8630 when completed. Call 598-4862 with questions.

Name________________________________Date of Birth:_____________Weight:_______Height:________

Do you have any allergies? (Y/N)___________ If Yes, Please list them:______________________________

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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:

YES	NO	
☐	☐	Have you ever had a MRI scan?
☐	☐	Cardiac pacemaker or defibrillator
☐	☐	Aneurysm clips in brain
☐	☐	Neurostimulator (TENS Unit) or insulin pump or Intrathecal pain pump
☐	☐	Vascular clip or intravascular filter, coil or stent, or swan ganz
☐	☐	Do you have any shunts?
☐	☐	Artificial heart valves
☐	☐	Breast tissue expander
☐	☐	Any ear implants/Hearing aids
☐	☐	Any eye implants
☐	☐	Tattoo eyeliner
☐	☐	Any orthopedic items (i.e. pins, rods, screws, nails, wires, or plates)
☐	☐	Any surgical clips, wire sutures, or surgical staples
☐	☐	Prosthesis or artificial limb or joint replacement
☐	☐	Dentures
☐	☐	Nitroglycerin or Nicotine patches
☐	☐	Penile Implant or IUD or diaphragm
☐	☐	Have you ever in your lifetime been a metal worker, grinder, welder, machinist, etc., as a hobby or profession?
☐	☐	Do you have any pieces of metal in your eyes?
☐	☐	Are you allergic to MRI contrast?
☐	☐	Are you on medication for diabetes ☐ and/or high blood pressure ☐
☐	☐	Do you have kidney disease, impairment, decreased renal function or on dialysis?
☐	☐	Do you have a history of liver disease, liver transplant, or pending a liver transplant?
☐	☐	Any metallic body such as shrapnel, gunshot wound or BB pellet
☐	☐	Are you nursing an infant?
☐	☐	Are you pregnant or do you suspect that you could be pregnant?
☐	☐	Will you need medication for pain ☐ and/or claustrophobia ☐
☐	☐	Have you ever had surgery? If so, when and what type? ______________________________

Please describe your symptoms and how long they have been present:____________________________

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Do you have any other pertinent medical problems?____

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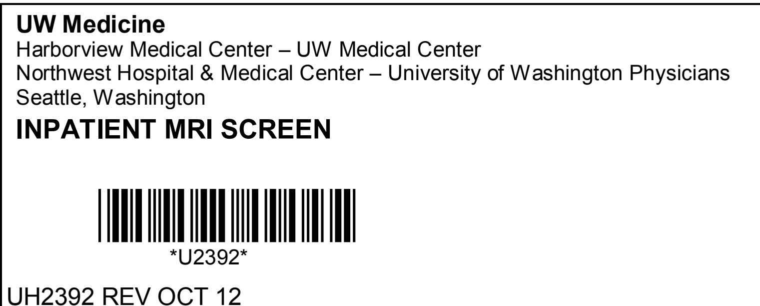
PATIENT SIGNATURE		DATE	FORM REVIEWED BY
WITNESS/RELATIONSHIP	PRINT NAME		DATE

PT.NO

NAME

DOB

Place EPIC Label Within Box



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