OUTPATIENT MRI SCREENING

门诊病人做 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

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 item s: 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 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 隆胸
☐	☐	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
☐	☐	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

PT.NO
NAME
DOB
Place EPIC Label Within Box

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WHITE - MEDICAL RECORD

YES 有	NO 无	
☐	☐	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, 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？
☐	☐	If you have a port, do you need it accessed?您已植有导管吗？是否要由那进入？
☐	☐	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？ ______
☐	☐	Would you like to listen to music during your exam? If so, what? 做核磁共振时您想听音乐吗？何种音乐？ ______

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

Place EPIC Label Within Box

DOB

UW Medicine
Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

OUTPATIENT MRI SCREEN - CHINESE

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WHITE - MEDICAL RECORD

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