DIAGNOSTIC IMAGING CENTERS, P.A.

MRI Screening Form

Office Use only

Creatinine_____mg/dl

eGFR _____ml/min/1.73m^2

WARNING: MRI system is always on! Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI. Do not enter the MRI scan room or MRI environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MRI exam room.

Patient Information

Name:_____ Date:_____

Age:_____ Date of Birth:_____ Weight:_____

❑Male ❑Female Body Part to be Examined:_____

Reason for MRI and/or symptoms:_____

How long have you had these symptoms?_____

Were you injured? ❑Yes ❑ No If so, when? _____

Medical Information

1. Have you had a reaction to contrast medium or dye used for imaging? ❑Yes ❑ No
   If yes, have you been premedicated? ❑Yes ❑ No
2. Have you had a prior imaging study (MRI, CT, Ultrasound, X-ray, etc.)? ❑Yes ❑ No
3. List prior surgeries:
   Type of surgery:_____ Date:_____
   Type of surgery:_____ Date:_____
4. Do you have: ❑ diabetes ❑ renal (kidney) disease ❑ kidney failure ❑ hypertension (high blood pressure)
   ❑ asthma ❑ respiratory disease ❑ sickle cell anemia/trait
   ❑ liver failure ❑ lupus ❑ systemic lupus erythematosus (SLE)
   ❑ allergies _____ _____
5. List current or recently taken medication and doses:_____ ❑ Unknown
   _____
6. Do you have a history of cancer? ❑Yes ❑ No
   If yes, describe type:_____
   Describe current or past treatments: (i.e., radiation or chemotherapy) _____
7. Smoking status:❑ Never ❑ Decline to state ❑ Current ❑ Former
   If current or former smoker: how many packs per day_____ **for how many years** _____
8. Please list any additional information you feel pertinent to today's exam:_____
   _____

For Female Patients Only

1. Date of last menstrual period:_____ Post-menopausal? ❑Yes ❑ No
2. Are you pregnant or experiencing a late menstrual period? ❑Yes ❑ No
3. Have you had a hysterectomy? ❑Yes ❑ No
   If yes, was it a **complete** hysterectomy? (removal of ovaries and uterus) ❑Yes ❑ No
   Date of surgery:_____
4. Are you currently breastfeeding? ❑Yes ❑ No

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Safety Information

1. Have you had an injury to the eye involving a metallic object or fragment, or were you a metal worker (e.g.metallic slivers, shavings, foreign body, etc.)? ❑Yes ❑ No

   If **yes**, has metal object been completely removed by a physician? ❑Yes ❑ No

   If **yes**, were you told "It's all out"? ❑Yes ❑ No

2. Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel, etc.)? ❑Yes ❑ No

   If **yes** to any above safety questions, please describe:_____

Please check all boxes for the following safety questions:

___	___	□ Yes □ No	Cardiac Pacemaker	___	___	□ Yes □ No	Claustrophobia
___	___	□ Yes □ No	Aneurysm clip(s)	___	___	□ Yes □ No	Radiation Seeds or Implants
___	___	□ Yes □ No	Implanted cardioverter defibrillator (ICD)	___	___	□ Yes □ No	Swan Ganz or thermodilution catheter
___	___	□ Yes □ No	Electronic implant or device	___	___	□ Yes □ No	Medication patch
___	___	□ Yes □ No	Neurostimulator system	___	___	□ Yes □ No	Wire mesh implant
___	___	□ Yes □ No	Magnetically-activated implant or device	___	___	□ Yes □ No	Any metallic fragment or foreign body
___	___	□ Yes □ No	Spinal cord stimulator	___	___	□ Yes □ No	Tissue expander (e.g. breast)
___	___	□ Yes □ No	Internal electrodes or wires	___	___	□ Yes □ No	Surgical staples, clips or metallic sutures
___	___	□ Yes □ No	Bone growth/bone fusion stimulator	___	___	□ Yes □ No	Joint replacement (hip, knee, etc.)
___	___	□ Yes □ No	Cochlear, otologic, or other ear implant	___	___	□ Yes □ No	Bone/joint pin, screw, nail, wire, plate, etc.
___	___	□ Yes □ No	Insulin or other infusion pump	___	___	□ Yes □ No	IUD, diaphragm, or pessary
___	___	□ Yes □ No	Implanted drug infusion device	___	___	□ Yes □ No	Dentures or partial plates
___	___	□ Yes □ No	Any type of prosthesis (eye, penile, etc.)	___	___	□ Yes □ No	Tattoo or permanent makeup
___	___	□ Yes □ No	Heart valve prosthesis	___	___	□ Yes □ No	Body piercing jewelry
___	___	□ Yes □ No	Eyelid spring or wire	___	___	□ Yes □ No	Hearing Aid
___	___	□ Yes □ No	Artificial or prosthetic limb	___	___	□ Yes □ No	Other implant_____
___	___	□ Yes □ No	Metallic stent, filter, or coil	___	___	□ Yes □ No	Seizure, motion disorder or breathing problem
___	___	□ Yes □ No	Exercise monitoring device				

WARNING: Before entering the MRI environment or MRI room, you must remove the following: medication patches, hearing aids, dentures, partial plates, keys, pens, cell phone, eyeglasses, hair pins, jewelry, body piercing jewelry, safety pins, watch, paperclips, money clip, credit cards, magnetic strip cards, coins, pocket knife, nail clipper, tools, clothing with metal.

*****WARNING***Medication patch causes burns to the skin if not removed.**

Please list any additional information you feel is pertinent to today's exam:_____

I attest that the above information is correct to the best of my knowledge. I understand the contents of this form and had the opportunity to ask questions regarding my MRI procedure.

_____	_____	_____	_____
Patient signature	**Technologist**	**Technologist**	**Date**

Medical Records Release

Please sign the medical release below. This allows our facility to obtain your previous exams or prior medical history as it pertains to today's exam.

Submitted to: _____
Name of facility
_____
_____

Patient Name: _____

Social Security #: _____ Date of Birth:_____

Type of records requested: _____

I hereby authorize and request you to release the complete medical records mentioned above, including copies of the reports in your possession, to Diagnostic Imaging Centers, P.A.

_____ _____
Patient or Authorized Person Date

STAFF USE ONLY

Staff Safety Notes:_____

_____

Staff Signature: _____

Discussion / Approval:_____