DIAGNOSTIC IMAGING CENTERS, P.A.

Office Use Only

Creatinine _____mg/dl

eGFR _____ml/min/1.73m^2

MRI Screening Form

Patient Information:

Name:_____ Date:_____ Date of Birth:_____ Age:_____

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 ***yes***, when?_____

☞ ***For Female Patients Only:*** Date of last menstrual period:_____ Are you Post-menopausal? ❑ Yes ❑ No

Are you pregnant or experiencing a late menstrual period? ❑ Yes ❑ No

Are you *currently* breastfeeding? ❑ Yes ❑ No

Have you had a hysterectomy? Date of surgery:_____ ❑ Yes ❑ No

*If ***yes***, was it a *complete* hysterectomy? (removal of ovaries and uterus) ❑ Yes ❑ No

Medical Information & History:

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. Please list any prior surgeries and dates: _____

_____

3. Do you have: ❑ Diabetes ❑ Liver failure ❑ Hypertension (high blood pressure)

❑ Kidney disease/recent kidney injury: _____

❑ Allergies: _____

4. List current or recently taken medication and doses: _____

_____ ❑ Unknown

5. Do you have a history of cancer? ❑ Yes ❑ No

*If ***yes***, describe type:_____

*Describe current or past treatments: (i.e., radiation or chemotherapy) _____

6. Smoking status: ❑ Never ❑ Current ❑ Former

***If *current OR former* smoker: ____ # of packs/day for _____ yrs.**

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

_____

8. Have you had a prior imaging study? (MRI, CT, Ultrasound, X-ray, etc.)? ❑ Yes ❑ No

*If ***yes***, please complete Medical Records Release below to allow our facility to obtain your previous exams or prior medical history as it pertains to today's exam.

Medical Records Release

Patient Name: _____

Date of Birth: _____

Type of records requested: _____

_____

Submitted to _____
Name of facility

_____
Street Address

_____
City, State, Zip

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

⚠ **WARNING:** MRI system is always on! Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI. **Before entering the MRI environment or MRI room, you must remove the following: medication patches, hearing aids, dentures, partial plates, keys, pens, cell phones, eyeglasses, hair pins, jewelry, body piercing jewelry, safety pins, watches, paperclips, money clips, credit cards, magnetic strip cards, coins, pocket knifes, nail clippers, tools, or anything containing metal. *Medication patches cause burns to the skin if not removed.**
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. ALL patients are REQUIRED to change into a gown prior to MRI scan due to safety reasons.

Safety Screening Questions:

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 YES OR NO for ALL of the following questions.

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

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 | Date | Technologist Signature

Staff Use Only

❑ We have verified with the manufacturer that the FDA has approved your implanted device to undergo imaging in the following MRI environment, under specified conditions, which our facility meets: ❑ 3T ❑ 1.5T ❑ 1.2T ❑ 0.35T

Staff Notes/Approval:_____

_____

_____

Technologist Signature: ✕_____ **Date:** _____