MRI PATIENT SCREENING SHEET

PATIENT NAME:_____
LAST NAME FIRST NAME MIDDLE INITIAL

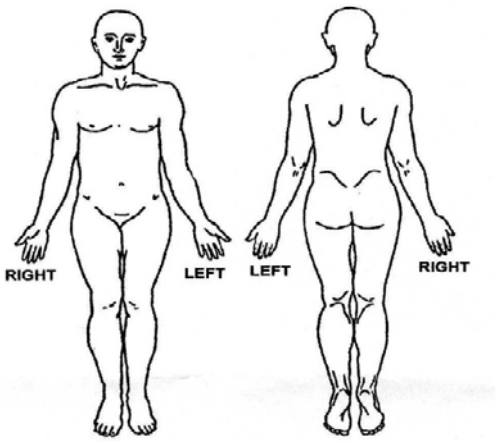
DOB: ___ /___ /_____ **MR#** _____

EXAM:_____

DOS: ___ /___ /_____ **FACILITY:**_____ **REFERRING PHYSICIAN:** _____

****LET US KNOW IF YOU HAVE A PACEMAKER, ANEURYSM CLIP OR HAVE HAD ANY BRAIN SURGERY****

PATIENT WEIGHT: _____ HEIGHT: _____
LIST SYMPTOMS/PROBLEMS ARE YOU EXPERIENCING: _____
_____
ANY SURGERY RELATED TO AREA **YES** OR **NO** (PLEASE CIRCLE)
IF YES, PLEASE LIST: _____
LIST MOST RECENT RELATED EXAMS/DATES/FACILITY: _____
_____
ALLERGIES TO MEDICATIONS OR DRUGS **YES** OR **NO** (PLEASE CIRCLE)
IF YES, LIST: _____
_____
HISTORY OF CANCER: **YES** OR **NO** (PLEASE CIRCLE)
TYPE: _____ DATE OF DIAGNOSIS:_____
TREATMENT-RADIATION AND/OR CHEMOTHERAPY (PLEASE CIRCLE): _____
DATES OF TREATMENT:_____



Mark your area of pain on the above figure

PLEASE CIRCLE YES OR NO IF YOU HAVE ANY OF THE FOLLOWING:

Cardiac pacemaker or pacing wires	Y	N	Body piercing jewelry	Y	N
Aneurysm clip	Y	N	Tattoo or permanent makeup	Y	N
AICD (Cardiac Defibrillator)	Y	N	Bone/Joint (pins, rods, replacement, etc.)	Y	N
Cochlear implant/ear implant	Y	N	Orbital Eye Prosthesis	Y	N
Biostimulator/Neurostimulator	Y	N	Any type of removable dental item	Y	N
Breast Tissue Expander	Y	N	TENS unit/electrodes	Y	N
Bone Growth Stimulator	Y	N	Prosthetic/Artificial limb	Y	N
Implanted Drug Infusion Device	Y	N	Hearing Aid	Y	N
Any type of Brain Surgery	Y	N	Ear Tubes	Y	N
Intraventricular Shunt	Y	N	Claustrophobia	Y	N
Intravascular filter/coil/stent	Y	N	Renal Disease/on dialysis	Y	N
Heart valve prosthesis	Y	N	Creatinine _____		
History of metal in eye	Y	N	***For male patients***		
Eyelid spring/wire	Y	N	Penile prosthesis		
Any metallic foreign body	Y	N	***For female patients***	Y	N
Insulin pump	Y	N	Diaphragm/IUD/Pessary		
Drug Patch (Nitroglycerin, Nicotine)	Y	N	Are you pregnant	Y	N
Any magnetically-activated implant	Y	N	Are you breast Feeding	Y	N
Any metal surgical clip or staple	Y	N		Y	N

I attest that the above information is correct to the best of my knowledge. I have read and understand the content of this form.
PATIENT/LEGAL GUARDIAN SIGNATURE

_____

DATE: ___ / ___ / _____

FOR OFFICE USE ONLY

I attest that I have reviewed the above history and safety information with the patient and/or legal guardian. Tech Initial_____
Date: ___ / ___ / _____

Gadolinium _____cc LotNo./Expiration Date _____ Injection performed by Technologist/RN_____
5mL NDC 50419-188-05 _____ 15mL NDC 50419-188-15 _____ 20mL NDC 50419-188-02 _____

Physician Signature_____ Date: ___ / ___ / _____ Time: _____
**My signature confirms I was present during the injection of contrast*