MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date ___/___/___ Patient Number _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

Date of Birth ___/___/___ Male ☐ Female ☐ Body Part to be Examined _____

month day year
Address _____ Telephone (home) (___) ___-_____

City _____ Telephone (work) (___) ___-_____

Prefecture _____ Zip Code _____

Reason for MRI and/or Symptoms _____

Referring Physician _____ Telephone (___) ___-_____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☐ No ☐ Yes
If yes, please indicate the date and type of surgery:
Date ___/___/___ Type of surgery _____
Date ___/___/___ Type of surgery _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ☐ No ☐ Yes
If yes, please list: Body part Date Facility
MRI _____ ___/___/___ _____
CT/CAT Scan _____ ___/___/___ _____
X-Ray _____ ___/___/___ _____
Ultrasound _____ ___/___/___ _____
Nuclear Medicine _____ ___/___/___ _____
Other_____ _____ ___/___/___ _____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes
If yes, please describe: _____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ No ☐ Yes
If yes, please describe: _____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes
If yes, please describe: _____
6. Are you currently taking or have you recently taken any medication or drug? ☐ No ☐ Yes
If yes, please list:_____
7. Are you allergic to any medication? ☐ No ☐ Yes
If yes, please list:_____
8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ☐ No ☐ Yes
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? ☐ No ☐ Yes
If yes, please describe: _____

For female patients:

10. Date of last menstrual period:___/___/___ Post menopausal? ☐ No ☐ Yes
11. Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ☐ No ☐ Yes
13. Are you taking any type of fertility medication or having fertility treatments? ☐ No ☐ Yes

If yes, please describe: _____

14. Are you currently breastfeeding? ☐ No ☐ Yes

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Please indicate if you have any of the following:

☐ Yes ☐ No Aneurysm clip(s)
☐ Yes ☐ No Cardiac pacemaker
☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
☐ Yes ☐ No Electronic implant or device
☐ Yes ☐ No Magnetically-activated implant or device
☐ Yes ☐ No Neurostimulation system
☐ Yes ☐ No Spinal cord stimulator
☐ Yes ☐ No Internal electrodes or wires
☐ Yes ☐ No Bone growth/bone fusion stimulator
☐ Yes ☐ No Cochlear, otologic, or other ear implant
☐ Yes ☐ No Insulin or other infusion pump
☐ Yes ☐ No Implanted drug infusion device
☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)
☐ Yes ☐ No Heart valve prosthesis
☐ Yes ☐ No Eyelid spring or wire
☐ Yes ☐ No Artificial or prosthetic limb
☐ Yes ☐ No Metallic stent, filter, or coil
☐ Yes ☐ No Shunt (spinal or intraventricular)
☐ Yes ☐ No Vascular access port and/or catheter
☐ Yes ☐ No Radiation seeds or implants
☐ Yes ☐ No Swan-Ganz or thermodilution catheter
☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
☐ Yes ☐ No Any metallic fragment or foreign body
☐ Yes ☐ No Wire mesh implant
☐ Yes ☐ No Tissue expander (e.g., breast)
☐ Yes ☐ No Surgical staples, clips, or metallic sutures
☐ Yes ☐ No Joint replacement (hip, knee, etc.)
☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
☐ Yes ☐ No IUD, diaphragm, or pessary
☐ Yes ☐ No Dentures or partial plates
☐ Yes ☐ No Tattoo or permanent makeup
☐ Yes ☐ No Body piercing jewelry
☐ Yes ☐ No Hearing aid
(Remove before entering MR system room)
☐ Yes ☐ No Other implant _____
☐ Yes ☐ No Breathing problem or motion disorder
☐ Yes ☐ No Claustrophobia

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if
you have any question or concern BEFORE you enter
the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge.
I read and understand the contents of this form and had the opportunity to ask questions regarding the informationon this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ___/___/___
Signature

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse _____ _____
Print name Relationship to patient

Form Information Reviewed By: _____ _____
Print name Signature

☐ MRI Technologist ☐ Nurse☐ Other_____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy).
Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Physician BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please mark on the figure(s) below
the location of any implant or metal
inside of or on your body.