dms HEALTH TECHNOLOGIES*

MAGNETIC RESONANCE IMAGING (MRI) SCREENING FORM

PATIENT INFORMATION			
Name:	Date of Birth:	Weight:	Home Phone:
Exam Requested: Ordering Physician:			Patient ID #:
Reason for Exam and/or Symptoms:			Facility Name:

PATIENT SCREENING	YES	NO
Have you ever had an injury to the eye involving a metallic object (e.g. metallic slivers, grinding, shrapnel etc) • If YES, orbit x-rays must be done and read by a radiologist prior to scheduling an MRI unless assured by the physician that all metal was removed following the injury. (Completed? ☐Yes ☐No)		
Do you experience claustrophobia in small spaces or have difficulty lying flat and holding still for 30 minutes? • If needed, contact your doctor to arrange medication before the day of the scan. (Arranged? ☐Yes ☐No)		
Are you older than 60 years, or have you been diagnosed with high blood pressure, diabetes, kidney disease or failure (on dialysis). Do you have only one kidney, or have you had a kidney transplant? Are you currently undergoing chemotherapy treatments (within last 2 weeks)? • If yes, and contrast is likely to be used, a creatinine must be obtained prior to scan. Scr: _____mg/dl		
(Female patients): Are you pregnant or suspect that you may be pregnant? • If you are breastfeeding, please inform the technologist.		

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING	YES	NO
MRI cannot be done if yes to the following:		
• Brain aneurysm clip(s) * (Some are now "safe" but **must** have prior written approval by the radiologist.)		
• Pacemaker or implanted wires		
• Implanted cardioverter defibrillator (ICD)		
• Implanted neurostimulator, or other electronic stimulation devices		
• Cochlear (ear) implant or implanted hearing aid		
• Magnetic dentures or other prostheses when the magnet is implanted in the body		
MRI may be done if yes to the following, but implants must be researched before appointment:		
• CSF Shunt with programmable valve		
• Implanted insulin or drug infusion pump		
• Ear implants		
• Breast tissue expander (not including permanent breast implants)		
• Penile implant		
• Carotid (neck) artery clamp (clips are o.k.)		
• Stents, coils, filters (if less than 6 weeks post op need card stating MRI compatibility)		
• Brain surgery		
• Detached retina clip or eye spring		
• Swallowed GI PillCam or Gastroscope or Colonoscope (check yes ***only*** if within 4 weeks)		
• Shrapnel (location?)		

Please indicate (Yes or No) and inform the technologist if you have any of the following (check all on that apply):

Artificial joint(s) or orthopedic pins ..... ☐Yes ☐No
Hearing aids (**please remove**) ..... ☐Yes ☐No
Medication or nicotine patches (remove if possible)... ☐Yes ☐No
Tattoos..... ☐Yes ☐No
Body piercing jewelry (**please remove**)..... ☐Yes ☐No
Dentures, partials, or braces..... ☐Yes ☐No

ATTESTATION

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

Signature of Patient (or Responsible Party):	Date: / /
Interviewer's name: Technologist's name:	

Please complete the questions on the other side

MEDICAL HISTORY

Patient Name:	Technologist Name:
What complaints or symptoms led you to seek medical help?	
How long have you had these symptoms or this pain? What makes the symptoms/pain better or worse?	
Was this an injury? ☐ Yes ☐ No	Date of injury:
Describe the injury.	
Have you ever had surgery to this area? ☐Y ☐N If yes to either, what type and when:	Have you ever had an MRI done on this area? ☐Y ☐N
Do you have a personal history of cancer? If yes, what type:	

Symptoms (check all that apply):

☐	Numbness	☐	Tingling	☐	Burning	☐	Dizziness
☐	Weakness	☐	Headaches	☐	Nausea/Vomiting	☐	Blurred Vision
☐	Swelling	☐	Mass or Bump	☐	Fever/Chills	☐	Incontinence
☐	Clicking Joint	☐	Decrease ROM	☐	Catching Sensations	☐	Stiffness
☐	Pain (Describe):						

Technologist Notes:

USE APPROPRIATE DIAGRAM TO SHOW LOCATION OF SYMPTOMS