

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: _____

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

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

- | | YES | NO |
|---|--------------------------|--------------------------|
| Have you experienced any problem related to a previous MR examination or MR procedure?
If yes, please describe: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)?
If yes, please describe: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?
If yes, please describe: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently taking or have you recently taken any medication or drug?
If yes, please list: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a history of asthma, allergic reaction, respiratory disease or reaction to a contrast medium or dye used for an MR, CT, or X-ray examination? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease or seizures?
If yes, please describe: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

FOR FEMALE PATIENTS:

- | | | | |
|---|------------------|--------------------------|--------------------------|
| Date of last menstrual period: ____/____/____ | Post menopausal? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you pregnant or experiencing a late menstrual period? | | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking oral contraceptives or receiving hormonal treatment? | | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking any type of fertility medication or having fertility treatments?
If yes, please describe: _____ | | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently breast-feeding? | | <input type="checkbox"/> | <input type="checkbox"/> |

I understand that there is no known harmful side effects associated with MRI and that MRI is an FDA approved procedure. It is advisable in certain instances to give patients an injection of paramagnetic contrast material to better detect abnormalities. Paramagnetic contrast agents have a very good safety record and it is extremely unusual to have any significant unfavorable side effects. There have been occasional headaches and nausea following injection. 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 information on this form and regarding the MR procedure that I am about to undergo. I hereby give my consent to the Columbia Medical Group, P.A., MRI Department to perform the MR procedure ordered by my physician, and consent to the use of paramagnetic contrast and/or medication for the purpose of sedation if ordered by my physician.

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

Form completed by: Patient Relative Nurse _____
Print name Relationship of patient

Form Information Reviewed by: _____
Print name Signature