

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS



Please Bring to your MRI Appointment at 2778 Webb Road, Wichita, KS 67226 • 316-631-1600

Today's Date: ___/___/___ Chart # _____

Name _____ Age: _____ Height: _____ Weight: _____

Date of Birth: ___/___/___ Gender: M F AOA Physician: _____

Address: _____ Phone - home: _____ work: _____ cell: _____

City: _____ State: _____ Zip: _____

Body Part to be examined: _____

Reason for MRI Symptoms:

Patient History

1. Have you had prior surgery on the area being scanned? No Yes
If yes, please describe: _____

2. Have you had any prior diagnostic imaging study (MRI, CT, Ultrasound, X-rays) of the body part being scanned today? No Yes

If yes, please list: Study _____ Date ___/___/___ Facility: _____
Study _____ Date ___/___/___ Facility: _____

3. Have you ever had an injury to the eyes involving a metallic object or fragment (metallic slivers, shavings, foreign body , etc)? No Yes

4. Have you ever been injured by a metallic object or foreign body (bullet, BB, shrapnel, etc)? No Yes
If yes, please describe: _____

5. Do you weigh more than 440 pounds? No Yes

For Female Patients:

6. Are you pregnant, or is there a possibility of you being pregnant? No Yes

7. Are you currently breastfeeding? (note esp if contrast study) No Yes

Note: See separate form if your MR procedure is a contrast study

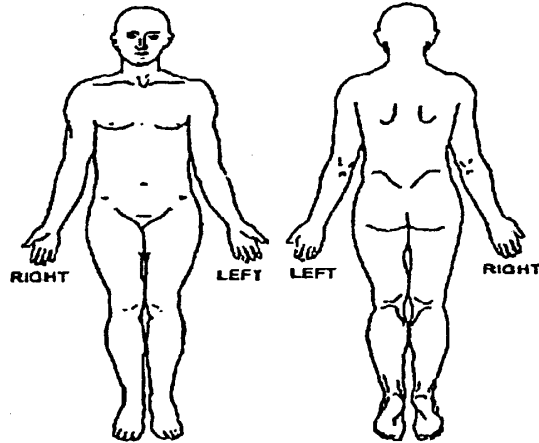


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have ANY question or concern regarding an implant, device, or object.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

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
- Yes No Other implant _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia

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



IMPORTANT INSTRUCTIONS

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 information on 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 Radiologist Other _____