MRI Screening Form

Name: [pname] DOB: [dob] Age: [age] Sex: [sex]

Reason for MRI and/or Symptoms: _____

Height: _____ Weight: _____ Music during exam: _____

Have you had prior surgery or an operation (i.e., arthroscopy, endoscopy, etc.) ☐ Yes ☐ No
If yes, please indicate the date and type of surgery: _____

Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ☐ Yes ☐ No
If yes, Please list: Exam Type Body Part Date Facility
_____ _____ ___/___/_____ _____

Have you had an injury to the eye involving a metallic object or fragment (i.e., metallic silvers, shavings, foreign body, etc.)? If yes, please describe: _____ ☐ Yes ☐ No

Do you have an 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? ☐ Yes ☐ No
If yes, please describe: _____

For Female Patients: Date of last menstrual period: ____ / ____ / _____ Post menopausal? ☐ Yes ☐ No

Are you pregnant or experiencing a late menstrual period? ☐ Yes ☐ No

Are you taking oral contraceptives or receiving hormonal treatments? ☐ Yes ☐ No

Are you taking any type of fertility medication or having fertility treatments? ☐ Yes ☐ No
If yes, please describe: _____

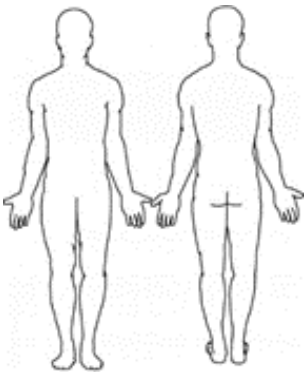
Are you currently breastfeeding? ☐ Yes ☐ No

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. Do not enter the MR system room or MR environment if you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist 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) or shunt
☐ Yes ☐ No Cardiac Pacemaker/Defibrillator (ICD)
☐ Yes ☐ No Electronic/Magnetically activated implant or device
☐ Yes ☐ No Neurostimulation system/Spinal cord stimulator
☐ Yes ☐ No Internal electrodes or wires
☐ Yes ☐ No Bone growth/bone fusion stimulator
☐ Yes ☐ No Cochlear, otologic, or other ear implant/hearing aid
☐ Yes ☐ No Insulin or other infusion pump
☐ Yes ☐ No Implanted drug infusion device
☐ Yes ☐ No Any type of prosthesis (i.e. 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 Vascular access port and/or catheter
☐ Yes ☐ No Radiation seeds or implants
☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
☐ Yes ☐ No Wire mesh implant
☐ Yes ☐ No Have you ever been injured by a metallic object or foreign body (i.e., BB, bullet, shrapnel, etc.)?

☐ Yes ☐ No Tissue expander (i.e. 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 partials
☐ Yes ☐ No Tattoo or permanent makeup
☐ Yes ☐ No Body piercing jewelry *(remove before entering MR room)*



Please mark on the figure to the left the location of any implant or metal inside the body.

IMPORTANT INSTRUCTIONS!

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

Please consult the MRI Technologist if you have any questions or concerns BEFORE you enter the MRI room. 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 MR procedure that I am about to undergo.

Signature of Patient or Authorized Representative **Date**

Technologist **Date**

Order Confirmed? (If yes, please initial) Tech:_____

CHARTER RADIOLOGY
WHERE COMPASSION AND EXPERTISE COME TOGETHER

MRI Contrast Consent

Your physician has requested that we perform an MRI scan. As part of your exam, a contrast agent may be injected into your vein in order to produce better images of the part of the body being examined. If you wish to refuse the contrast injection, inform the technologist and the MRI will be conducted without the contrast agent. The following complications are possible: pain, bleeding, bruising at the injection site, and leakage of contrast from the needle under the skin, which may cause local discomfort. Allergic reactions in response to the contrast agent may include hives, shortness of breath or difficulty swallowing.

The safety of its use in pregnant women has not yet been determined. If you are breast-feeding, you should pump and discard your breast milk three times over a 24-hour period following this test. It is safe to resume breast-feeding 24 hours after this test.

If you have previously had a reaction to a contrast injection, have a history of asthma or other allergic conditions, kidney disease or are currently undergoing dialysis, YOU MUST INFORM THE TECHNOLOGIST. Patients with diminished or absent kidney function who receive gadolinium, particularly at high doses, are at risk for developing a serious, potentially life-threatening condition known as nephrogenic systemic fibrosis (NSF).

I have read, had the opportunity to ask questions, and understand the above information and give consent for the administration of intravenous contrast and/or oral contrast as indicated.

Please answer the following questions:	**Select**	**Yes or No**
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?	☐ YES	☐ NO
Are you currently taking or have recently taken any medications or drugs? If **yes**, please list: _____	☐ YES	☐ NO
Are you allergic to any medication? If **yes**, please list: _____	☐ YES	☐ NO
Do you have an anemia or any disease(s) that affect your blood, a history of renal (kidney) disease, renal (kidney) failure, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures?	☐ YES	☐ NO
Have you had a kidney transplant? (If **yes,** we will not administer contrast)	☐ YES	☐ NO

[fname] [lname]	[dob]	[age]	[mrn]
Patient's Name (printed)	Date of Birth	Age	Medical Record Number

Signature of Patient or Authorized Representative — Date

Charter Radiology Witness