



MRI PROCEDURE SCREENING FORM

PATIENT NAME _____ WEIGHT _____ BIRTHDATE _____

EXAM _____ DIAGNOSIS _____

REFERRING DR. _____ PRIMARY DR. _____

Please describe your pain, discomfort and/or symptoms relating to your MRI today.

Have you ever had surgery? YES NO

Please list surgeries _____

Since birth to present:

Have you ever had metal in your eyes? (i.e. bullet, bb, shrapnel, metallic shavings) YES NO

If yes, please describe _____

Have you ever had metal in your body? YES NO

If yes, please describe _____

Date of last menstrual period _____

Are you breast feeding? YES NO

Are you pregnant? YES NO

Have you ever had a reaction to contrast or MR/CT/IVP procedure? YES NO

Please check any of the following that you have had:

Seizures Kidney Disease Asthma Drug Allergies

Anemia Other diseases that affect your blood _____

Cancer If yes, what type? _____

Please list any allergies: _____

Please list any/all of the following types of procedures you have had:

<i>Exam</i>	<i>Date and facility</i>	<i>Exam performed for what type of problems</i>
Xray	_____	_____
Ultrasound	_____	_____
CT Scan	_____	_____
MRI	_____	_____
Nuclear Medicine	_____	_____

We will provide you with a set of earplugs to quiet the high level of noise you may experience during your procedure.

FOR OFFICE USE ONLY BELOW THIS LINE

Tech Comments: _____

INT Size _____ Location _____ Irrigates w/o resistance YES NO Tech _____

Contrast _____ Amount _____ Radiologist _____

INT DC'd: YES NO IV within normal limits YES NO Discharge Time _____

Change from initial assessment? YES NO

TEACHING DATA:

Type of procedure: _____

Procedure and pre and post preparation explained to:

Patient Father Mother Guardian Other _____ Tech Signature _____

Verbalizes understanding of procedure and post procedure instructions: YES NO

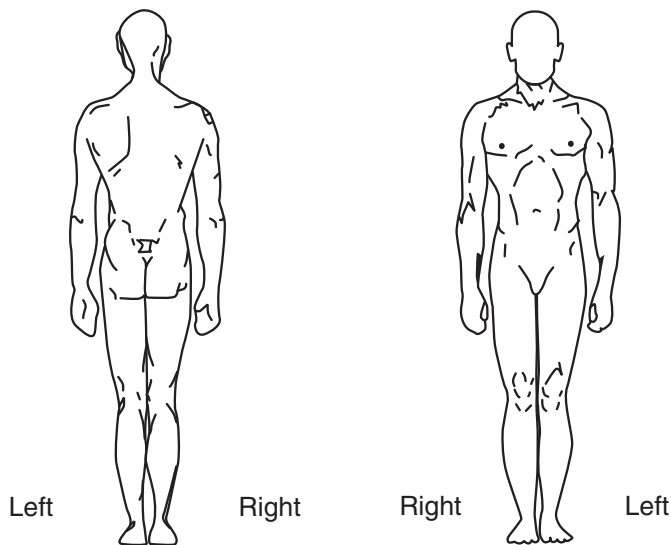
Please Indicate If You Have Any Of The Following:

If you mark any of the below that has an asterisk, please provide a card given to you by your physician explaining what the device is and what it is made of.

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Cardiac pacemaker <input type="checkbox"/> Aneurysm clip(s) <input type="checkbox"/> Implanted cardiac defibrillator <input type="checkbox"/> Neurostimulator <input type="checkbox"/> Implanted insulin pump <input type="checkbox"/> Swan-Ganz catheter <input type="checkbox"/> Heart valve prosthesis <input type="checkbox"/> Hearing aid <input type="checkbox"/> Any type of ear implant <input type="checkbox"/> Penile prosthesis <input type="checkbox"/> Orbital/eye prosthesis <input type="checkbox"/> Intraventricular shunt <input type="checkbox"/> Artificial limb or joint <input type="checkbox"/> Dentures <input type="checkbox"/> IUD <input type="checkbox"/> Tattooed eyeliner | <ul style="list-style-type: none"> <input type="checkbox"/> Any type of biostimulator TYPE _____ <input type="checkbox"/> Halo vest or metallic cervical fixation device <input type="checkbox"/> Any type of implant held in place by a magnet <input type="checkbox"/> Any type of surgical clip or staple <input type="checkbox"/> Any type of foreign body, shrapnel, or bullet <input type="checkbox"/> Implanted drug fusion device <input type="checkbox"/> Pessary <input type="checkbox"/> Any type of electronic, mechanical or magnetic implant
TYPE _____ <input type="checkbox"/> Any type of intravascular coil, filter or stent
(Gianturco coil, Gunther IVC filter, Palmaz stent) <input type="checkbox"/> Any type of internal electrodes, including Pacing wires,
Cochlear implant OTHER _____ <input type="checkbox"/> Any implanted orthopedic item (pins, rods, screws,
nails, clips, plates, wires...) TYPE _____ |
|--|--|

A small percentage of patients with tattooed eyeliner have experienced transient skin irritation with MRI. You must decide if this slight risk warrants undergoing your examination. You may want to discuss this matter with your referring physician.

Please shade areas of the body where you are experiencing pain.



I hereby attest that the information I have given is true, correct and complete to best of my knowledge. I have read documents in its entirety and understand its content. I further state that I have been given the opportunity to have addressed any concerns I may have regarding any of the questions I have answered, as well as questions or concerns I may have regarding the procedure I am scheduled to undergo and thereby hold Pinnacle Medical Center harmless hereof.

Signature _____ Date _____