MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM

For Patients

BORLAND GROOVER
Imaging Center

Date _____ / _____ / _____

Name (First, Middle Initial, Last) _____

Date of Birth _____ / _____ / _____ Age _____ Height _____ Weight _____

Please list all surgeries in your lifetime and the years they were performed:

Do you have history of metal welding/grinding, or had metal in your eye(s)? **YES** **NO**

Have you ever been injured by a metallic object or foreign body? **YES** **NO**
(e.g.: BB, bullet, shrapnel, lead, etc.)

Have you ever had an allergic reaction to MRI contrast media (gadolinium)? **YES** **NO**

If yes, please explain: _____

Have you ever had a pill camera/video capsule endoscopy? **YES** **NO**

If yes, please indicate:

Date the pill was taken: _____ / _____ / _____ Date you passed the pill: _____ / _____ / _____

For Female Patients:

First day 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 treatment? **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**

IT IS THE STANDARD POLICY AT BORLAND GROOVER THAT ALL FEMALE PATIENTS OF CHILD BEARING AGE (WHO HAVE NOT HAD A HYSTERECTOMY) WILL PROVIDE A URINE SAMPLE FOR PREGNANCY TESTING PRIOR TO THE START OF THE MRI PROCEDURE.

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For Patients

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Name (First, Middle Initial, Last) _____ Date of Birth _____ / _____ / _____

WARNING: Certain implants, devices, or objects may be hazardous to your 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 questions or concerns 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.

Before entering the MR environment or 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 jewelry, watch, safety pins, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocketknife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads. Please consult with the MRI Technologist or Radiologist if you have any questions or concerns BEFORE you enter the MR system room.

Please indicate if you have any of the following:

YES **NO** Aneurysm clip(s) and/or coils
YES **NO** Cardiac pacemaker
YES **NO** Implanted cardioverter defibrillator (ICD)
YES **NO** Electronic implant or device
YES **NO** Neurostimulator or deep brain stimulator
YES **NO** Spinal cord, bone, gastric or bladder stimulator
YES **NO** Feeding tube with mercury tip
YES **NO** Organ transplant or on waiting list (indicate organ) _____
YES **NO** Cochlear, otologic, stapes or other ear implant
YES **NO** Insulin or other infusion pump
YES **NO** Implanted drug infusion device or pain pump
YES **NO** Any type of prosthesis (eye, penile, limb etc.)
YES **NO** Removable glucose monitoring device or medication patch on your skin
YES **NO** Eyelid spring/wire or glaucoma shunt
YES **NO** Metallic stent, filter, coil, shunt (spinal or intra-ventricular)
YES **NO** Vascular access port and/or catheter
YES **NO** Radiation seeds or implants
YES **NO** Wire mesh implant
YES **NO** Swan-Ganz or thermodilution catheter
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** Body tattoo or permanent makeup
YES **NO** Body piercing jewelry
YES **NO** Hearing aid
YES **NO** Kidney disease/impaired renal or kidney function
YES **NO** Diabetes
YES **NO** High blood pressure / hypertension
YES **NO** Dialysis
YES **NO** Kidney surgery or only 1 kidney
YES **NO** Gout
YES **NO** Proteinuria (protein in your urine)
YES **NO** IV injection of contrast in the past month
YES **NO** Asthma, emphysema or COPD (please circle)

NOTE: You are 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 have read and understand the contents of this form and have been offered a copy of the contrast medication guide. I have had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. As a patient, I have reviewed and understand the metal items, including but not limited to the previously stated examples, are harmful to me, the technologist and the MRI scanner. Also, by signing, I am stating that I will comply with all metal items, including but not limited to the previously stated examples, being removed from my person and that I understand these items will not be permitted in the MRI scan suite. A secured location will be provided for your belongings.

Signature of person completing form _____ Date _____ / _____ / _____
Form completed by: (please circle) PATIENT RELATIVE OTHER (print name) _____

Form information reviewed MRI Technologist (signature) _____