MRI - PATIENT INFORMATION SHEET

Scanned_____
Screened_____

Name: _____ Procedure(s)_____
Date: _____ MR#_____
Sex:_____ Age:_____ DOB:_____ Ht:_____ Weight:_____
Physician:_____
Diagnosis:_____

Previous Illness: Cancer: ☐ No ☐ Yes If yes, explain:_____

Treated ☐ No ☐ Yes Radiation ☐ No ☐ Yes Chemo ☐ No ☐ Yes
Year of treatment_____

History of renal disease, diabetes: ☐ No ☐ Yes If yes, describe_____

On dialysis: ☐ No ☐ Yes Creatinine level: _____GFR Calculation:_____

Previous surgery to area studied today: ☐ No ☐ Yes If yes, year:_____
Previous studies: ☐ CT ☐ MRI ☐ X-rays ☐Nuclear Med ☐ US
Locations: _____ _____ _____ _____ _____

Current Problem / Reason for today's MRI. Patient States: _____
_____
_____

MRI EXAM / SYMPTOMS

L-Spine MRI	Pain	☐No	☐Yes	☐Back	☐Rt Leg	☐Lt Leg
	Numbness	☐No	☐Yes	☐Back	☐Rt Leg	☐Lt Leg
	Weakness	☐No	☐Yes	☐Back	☐Rt Leg	☐Lt Leg
C-Spine MRI	Pain	☐No	☐Yes	☐Neck	☐Rt Arm	☐Lt Arm
	Numbness	☐No	☐Yes	☐Neck	☐Rt Arm	☐Lt Arm
	Weakness	☐No	☐Yes	☐Neck	☐Rt Arm	☐Lt Arm
Brain MRI	Headache	☐No	☐Yes			
	Seizures	☐No	☐Yes			
	Weakness	☐No	☐Yes	Duration_____	Location_____	
	Numbness	☐No	☐Yes	Duration_____	Location_____	
Extremity	Pain	☐No	☐Yes	Duration_____	Location_____	
	Previous Injections	☐No	☐Yes	When _____	Where_____	
	Injury	☐No	☐Yes	When _____	How _____	

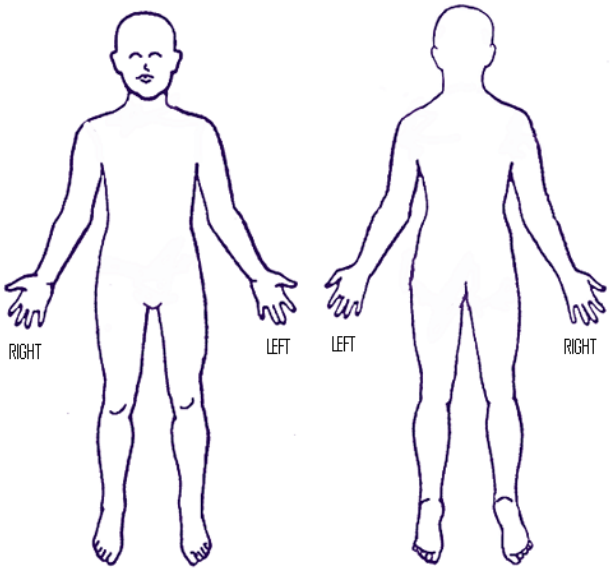
MRI - PATIENT SCREENING SHEET

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 implant
☐Yes ☐No Swan-Ganz or thermodilution catheter
☐Yes ☐No Medication patch (Nicotine, Nitroglycerine)
☐Yes ☐No Any metallic fragment or foreign body (eyes)
☐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 (*Remove prior to MR exam)*

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



Please mark on the figure(s) above 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 such as hearing aids, dentures, partial plates, keys, beeper, 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, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads, etc…
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.

Patient / Relative / Nurse Signature:_____ 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_____