

MRI SCREENING
DIAGNOSTIC IMAGING ASSOCIATES

DATE: _____

| | |
|--------------------------------|-----------------------------|
| NAME: _____ | D.O.B.: _____ |
| PHYSICIAN: _____ | HEIGHT: _____ WEIGHT: _____ |
| REASON FOR EXAM: _____ | LMP: _____ |
| ALLERGIES TO MEDICATION: _____ | Chance of Pregnancy: YES NO |

Have you ever had an MRI examination: NO YES-----Body Part: _____ When: _____
Facility: _____

Are you claustrophobic NO YES
Have you ever received a contrast (dye) injection for MRI? NO YES-----Complications?: _____

Do you have any respiratory problems? NO YES-----Describe: _____
Are you Diabetic? NO YES
Do you have any kidney problems? NO YES-----Describe: _____
(Acute / Chronic Renal Failure, Dialysis, Hepatorenal Syndrome)

Have you had any surgeries? NO YES-----TYPE: _____

Have you ever been injured by any METALLIC OBJECTS NO YES-----Describe: _____
(BB, Shrapnel, Bullets)?

Have you ever had any METALLIC OBJECTS IN YOUR EYES? NO YES-----Describe: _____
(Metal Slivers or Shavings)

**YOU MUST COMPLETE THIS ENTIRE SECTION ! PLEASE CIRCLE YES OR NO TO THE FOLLOWING
THE FOLLOWING ITEMS MAY BE HARMFUL TO YOU OR YOUR MRI PROCEDURE!!!**

| | | | |
|----------------------------------|----|-----|-----------------------------------|
| Cardiac Pacemaker | NO | YES | _____ |
| Cardiac Defibrillator | NO | YES | _____ |
| Aneurysm Clips | NO | YES | _____ |
| Spinal Fusion Surgery | NO | YES | _____ |
| Spinal Fixation Device(s) | NO | YES | _____ |
| Surgical Clips or Staples | NO | YES | _____ |
| Surgical Mesh | NO | YES | _____Type: _____ |
| Implanted Drug Pump | NO | YES | _____Type: _____ |
| Electrical / Mechanical Implant | NO | YES | _____Type: _____ |
| Magnetic Implants | NO | YES | _____Type: _____ |
| Shunt | NO | YES | _____Type: _____ |
| Stents / Coils / Filters | NO | YES | _____Type: _____ |
| Bio stimulator / Neurostimulator | NO | YES | _____Type: _____ |
| Body Piercings | NO | YES | _____Where: _____ |
| Penile implant | NO | YES | _____Type: _____ |
| IUD / Diaphragm / Pessary | NO | YES | _____Type: _____ |
| Wig, Hair Implants | NO | YES | _____ |
| Hearing Aid / Implants | NO | YES | _____ |
| Cochlear Implant | NO | YES | _____ |
| Artificial Heart Valve | NO | YES | _____ |
| Artificial Eye / Eyelid Springs | NO | YES | _____ |
| Tattoos / Permanent Cosmetics | NO | YES | _____Body Part: _____ When? _____ |
| Tissue Expander | NO | YES | _____ |
| Radiation Seeds (cancer) | NO | YES | _____ |
| Medication Patches | NO | YES | _____Type: _____ |

**I ATTEST THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE
I UNDERSTAND THIS FORM AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS REGARDING ITS CONTENTS**

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

| | | | |
|--------------------------|-------------------|--|-------------------------|
| DIABETICS: _____ | BUN _____ | CREATININE _____ | DATE DRAWN: _____ |
| DIALYSIS: _____ | CO2 (blood) _____ | CREATININE CLEARANCE (blood + urine) _____ | AMOUNT: _____ CC |
| CONTRAST INJECTED: _____ | PROHANCE _____ | MULTIHANCE _____ | SITE: _____ #ATT: _____ |
| DEVICE USED: JELCO | BUTTERFLY | GAUGE: _____ | RATE: _____ CC/SEC |
| INFUSED BY: _____ | BOLUS | POWER _____ | |

RN SIGNATURE: _____ RN DATE: _____