MRI Screening Form

METHODIST HEALTH SYSTEM
IMAGING SERVICES

Pt Name:_____ Preferred Name: _____

DOB: _____ Med Record Number: _____

Height: _____

Weight: _____

Attention patients: The MRI room contains a very strong magnet. Before you are allowed to enter the room, we must know if you have any metal in your body that could interfere with your scan or be harmful to you. To ensure your safety, **please answer the following questions carefully.**

☐ Yes ☐ No	Pacemaker, Defibrillator, Cardiac Monitor, or Leads	☐ Yes ☐ No	Bladder Stimulator (Interstim Stimulator)?
☐ Yes ☐ No	Cochlear or Stapes (inner ear) Implants	☐ Yes ☐ No	Breast tissue expander
☐ Yes ☐ No	Brain Aneurysm Clip	☐ Yes ☐ No	Neurostimulator/Spinal Cord Stimulator
☐ Yes ☐ No	Vascular Coil, Umbrella (filter for clots), Stent	☐ Yes ☐ No	Heart Valve or Stent
☐ Yes ☐ No	Gastrointestinal Device or Clips (PillCam, capsule, GI Clip or other)? Or Bowel procedure in last 30 days?		

If you answered "YES" to any of the questions in the box above, you may not be eligible to have an MRI exam. Please alert an MRI staff member or call 402-354-4717 to verify your eligibility.

Please answer the questions below.

☐ Yes ☐ No	Are you pregnant or nursing? **Please alert staff**	☐ Yes ☐ No	Prosthesis (limbs, joints or eyes)
☐ Yes ☐ No	Insulin or other implanted Drug infusion Pump	☐ Yes ☐ No	IUD, Penile Implant
☐ Yes ☐ No	Contrast Allergy -To what?_____	☐ Yes ☐ No	Eyelid Spring or wire
☐ Yes ☐ No	Hearing Aid (Remove before entering MR scan room)	☐ Yes ☐ No	Tattoo or Tattooed eyeliner/eyebrows
☐ Yes ☐ No	Transdermal Medication patch (Nicotine, Nitro, etc.)	☐ Yes ☐ No	Any surgery in the last 6 weeks
☐ Yes ☐ No	Shrapnel (metal fragments)/ Gunshot Injury	☐ Yes ☐ No	Any Vascular Clips
☐ Yes ☐ No	Metal fragments in eye due to grinding/welding	☐ Yes ☐ No	Bone growth/Bone fusion stimulator
☐ Yes ☐ No	Removable dentures, retainers, hair pieces	☐ Yes ☐ No	Any implant not listed above
☐ Yes ☐ No	Body Piercing – Remove before scan		

Please describe in your own words why your physician ordered an MRI exam today. (What is the problem? Where is the problem?)

☐ Yes ☐ No Do you have pain? If so, where?

_____

☐ Right ☐ Left ☐ Front ☐ Back

☐ Yes ☐ No Do you have a personal history of cancer?

Type of cancer? _____

When diagnosed? _____

☐ Yes ☐ No Have you had radiation or chemotherapy?

If YES, please describe and list the date. _____

☐ Yes ☐ No Have you had any surgeries on the body part being imaged today?

If YES, please list _____

☐ Yes ☐ No Any recent trauma or injury?_____

☐ Yes ☐ No Are you on dialysis?

☐ Yes ☐ No Are you diabetic?

All information above is correct to the best of my knowledge. I have read and understand the content on this form and have had the opportunity to ask questions regarding the MRI exam.

Patient Signature: _____ **Date:** _____ **Staff Signature:** _____

NOT PERMANENT PART OF MEDICAL RECORD
CC-MRISCREEN
Rev. 04/2021