

MRI Screening Form



METHODIST

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.**

<input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker, Defibrillator, Cardiac Monitor, or Leads	<input type="checkbox"/> Yes <input type="checkbox"/> No Bladder Stimulator (Interstim Stimulator)?
<input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear or Stapes (inner ear) Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No Breast tissue expander
<input type="checkbox"/> Yes <input type="checkbox"/> No Brain Aneurysm Clip	<input type="checkbox"/> Yes <input type="checkbox"/> No Neurostimulator/Spinal Cord Stimulator
<input type="checkbox"/> Yes <input type="checkbox"/> No Vascular Coil, Umbrella (filter for clots), Stent	<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Valve or Stent
<input type="checkbox"/> Yes <input type="checkbox"/> 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.

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

<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have pain? If so, where? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Any recent trauma or injury? _____
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Front <input type="checkbox"/> Back	<input type="checkbox"/> Yes <input type="checkbox"/> No Are you on dialysis?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a personal history of cancer? Type of cancer? _____ When diagnosed? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Are you diabetic?
<input type="checkbox"/> Yes <input type="checkbox"/> No Have you had <u>radiation</u> or <u>chemotherapy</u> ? If YES, please describe and list the date. _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any surgeries on the body part being imaged today? If YES, please list _____	

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:** _____