

**ST. VINCENT'S CATHOLIC MEDICAL CENTER
DEPARTMENT OF RADIOLOGY
MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS**

Date _____

Name _____ Age _____ Height _____ Weight _____
 Last name, First name Middle initial

Date of birth _____ Male Female Body part to be examined _____

Reason for MRI and/or symptoms _____

Referring physician _____ Telephone (____) _____

1. Have you had prior surgery of any kind, including implantable devices (e.g., joint replacement, aneurysm clip, pacemaker, heart valve, etc.)? No Yes

If yes, please indicate the date and type of surgery:

Date ____ / ____ / ____ Type of surgery _____

Date ____ / ____ / ____ Type of surgery _____

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, ULTRASOUND, X-ray, etc.)? No Yes
 Date _____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? If yes, please describe: No Yes

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? Or been a metal worker? No Yes
 If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? No Yes
 If yes, please describe: _____

6. Are you currently taking any medication or on a medication patch? No Yes
 If yes, please list: _____

7. Are you allergic to any medication? No Yes
 If yes, please list: _____

8. Do you have a history of asthma, allergic reaction, respiratory disease or reaction to a contrast medium or dye used for an MRI, CT or X-ray examination? No Yes

9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, seizures or sickle cell anemia? No Yes
 If yes, please describe: _____

For female patients:

10. Date of last menstrual period: ____ / ____ / ____ Post menopausal? No Yes

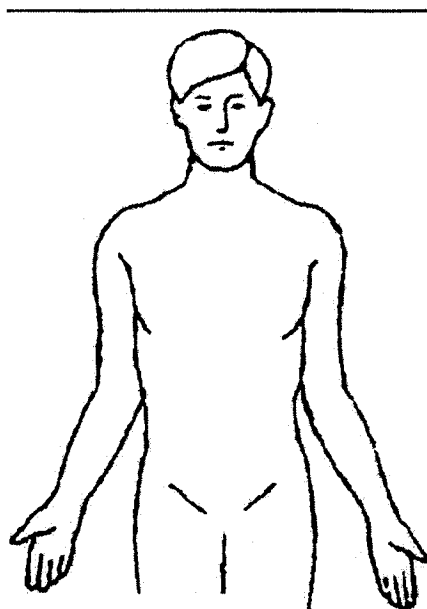
11. Are you pregnant or experiencing a late menstrual period? No Yes

12. Are you currently breastfeeding? No Yes

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each, of the following.

- Yes No Cardiac pacemaker
- Yes No Implanted cardiac defibrillator
- Yes No Aneurysm clip
- Yes No Carotid artery vascular clamp
- Yes No Neurostimulator
- Yes No Insulin or infusion pump
- Yes No Implanted drug infusion device
- Yes No Spinal fusion stimulator
- Yes No Cochlear, otologic, or ear implant
- Yes No Ear tubes
- Yes No Prosthesis (eye/orbital, penile, etc.)
- Yes No Implant held in place by a magnet
- Yes No Heart valve prosthesis
- Yes No Artificial limb or joint
- Yes No Other implants in body or head
- Yes No Electrodes (on body, head or brain)
- Yes No Intravascular stents, filters, or coils
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheters
- Yes No Swan-Ganz catheter
- Yes No Transdermal delivery system (Nitro.)
- Yes No IUD or diaphragm
- Yes No Pessary or bladder ring
- Yes No Tattooed eyeliner or eyebrows
- Yes No Body piercing(s)
- Yes No Metal fragments (eye, head, ear, skin)
- Yes No Internal pacing wires
- Yes No Aortic clips
- Yes No Venous umbrella
- Yes No Metal or wire mesh implants
- Yes No Wire sutures or surgical staples
- Yes No Harrington rods (spine)
- Yes No Metal rods in bones; joint replacements
- Yes No Bone/joint pin, screw, nail, wire, plate
- Yes No Hearing aid (*Remove before scan*)
- Yes No Dentures (*Remove before scan*)
- Yes No Breathing or motion disorders
- Yes No Claustrophobia
- Yes No Other:

Please mark on the figure below, the location(s) of any implants or metal inside or on your body.



Right

Left

Please remove all metallic objects before MRI including: Eye make-up, keys, hairpins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material.

YOU ARE REQUIRED TO WEAR EARPLUGS OR EARPHONES DURING THE MRI EXAMINATION.

Signature of Person Completing Form

_____/_____/_____
Date

Form Completed by: Patient Relative: _____

Name & relationship to patient

Signature of Physician or Technologist: _____