BORLAND GROOVER IMAGING CENTER

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date_____ / _____ / _____ Patient Number_____

Name_____ Age_____ Height_____ Weight_____
Last name First name Middle Initial

DOB_____ / _____ / _____ Male ❑ Female ❑ Body Part to be Examined _____
month day year

Reason for MRI and/or Symptoms _____

Referring Physician _____ Telephone (_____) _____- _____

Emergency Contact_____ Telephone (_____) _____- _____

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1. Please list all surgeries in your lifetime and the year(s) they were performed: **Do you have a card?_____**

Surgery	Year	Surgery	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

If yes, please list:	Body part	Date	Facility
MRI	_____	_____/_____/_____	_____
	_____	_____/_____/_____	_____
CT/CAT Scan	_____	_____/_____/_____	_____
	_____	_____/_____/_____	_____
X-Ray	_____	_____/_____/_____	_____
	_____	_____/_____/_____	_____
Ultrasound	_____	_____/_____/_____	_____
	_____	_____/_____/_____	_____
Nuclear Medicine	_____	_____/_____/_____	_____
	_____	_____/_____/_____	_____
Other_____	_____	_____/_____/_____	_____
	_____	_____/_____/_____	_____

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3. Have you experienced any problem related to a previous MRI examination or MR procedure? ❑ No ❑ Yes

   If yes, please describe:_____

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

   _____

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 or have you recently taken any medication or drug and/or do you have a medical patch? ❑ No ❑ Yes

   If yes, please list: _____

   _____

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

   _____

   _____

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction or 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, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? ❑ No ❑ Yes

10. Have you ever had a pill camera/capsule endoscopy? ❑ No ❑ Yes

    If yes, please list date pill taken:_____/_____/_____ and date pill passed:_____/_____/_____

    If yes, please describe:_____

For Female Patients:

11. First day of last menstrual period: _____/_____/_____ Post menopausal? ❑ No ❑ Yes

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

13. Are you taking oral contraceptives or receiving hormonal treatment? ❑ No ❑ Yes

14. Are you taking any type of fertility medication or having fertility treatments? ❑ No ❑ Yes

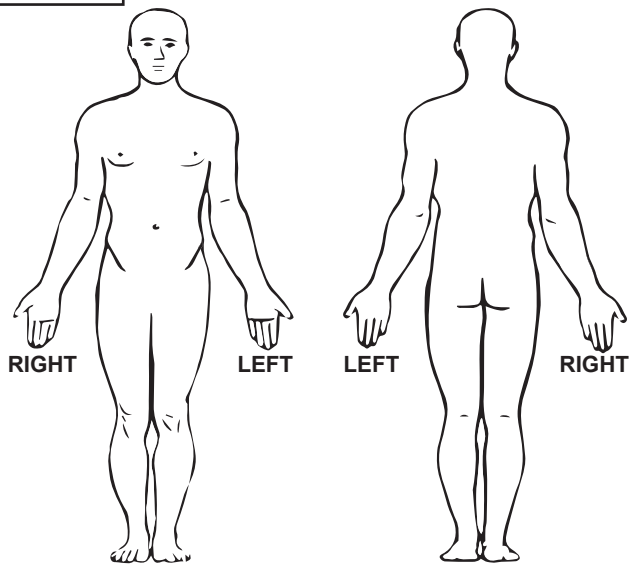
    If yes, please describe:_____

15. Are you currently breastfeeding? ❑ No ❑ Yes

It is the standard policy at Borland-Groover Imaging Center that all female patients between the ages of 12 and 56 who have not had a hysterectomy will provide a urine sample for pregnancy testing prior to the start of the MRI examination.

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 mark on the figure(s) below the location of any implant or metal found inside of or on your body.



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 intra-ventricular)
❑ Yes ❑ No Sitz Markers
❑ Yes ❑ No Vascular access port and/or catheter
❑ Yes ❑ No Radiation seeds or implants
❑ Yes ❑ No Swan-Ganz or thermodilution catheter
❑ Yes ❑ No Medication patch (Nicotine, Nitroglycerine, pain, etc.)
❑ Yes ❑ No Any metallic fragment or foreign body
❑ 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 before entering MR system room)*
❑ Yes ❑ No Other implant_____
❑ Yes ❑ No Breathing problem or motion disorder
❑ Yes ❑ No Claustrophobia
❑ Yes ❑ No BBs, bullets, shrapnel
❑ Yes ❑ No Anything in your body that you were NOT born with. If yes, please list: _____
_____

IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove ALL metallic objects including 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, and clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You are 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 have 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. As a patient, I have reviewed and understand the metal items, including but not limited to the previously stated examples, are harmful to myself, the technologist and the MRI Scanner. Also, by signing, I am stating that I will comply with all metal items, including but not limited to the previously stated examples, being removed from my person and that I understand these items will not be permitted in the MRI Scan suite. A secured location will be provided for your belongings.

Signature of Person Completing Form: _____ Date: _____/_____/_____
Signature

Form Completed By: ❑ Patient ❑ Relative ❑ Nurse _____
Print Name Relationship to Patient

1. Form Information Reviewed By: _____
Print Name Signature

❑ MRI Technologist ❑ Nurse ❑ Other Title_____

2. Form Information Reviewed By: _____
Print Name Signature

❑ MRI Technologist ❑ Nurse ❑ Other Title_____