

**BORLAND GROOVER IMAGING CENTER
MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS**

Date _____ / _____ / _____

Name (First, Middle Initial, Last) _____

Date of Birth _____ / _____ / _____ Age _____ Height _____ Weight _____

Please list all surgeries in your lifetime and the years they were performed:

Surgery	Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have history of metal welding/grinding, or had metal in your eye(s)? YES NO

Have you ever been injured by a metallic object or foreign body?
(e.g.: BB, bullet, shrapnel, lead, etc.) YES NO

Have you ever had an allergic reaction to MRI contrast media (gadolinium)? YES NO

If yes, please explain: _____

Have you ever had a pill camera/video capsule endoscopy? YES NO

If yes, please indicate:

Date the pill was taken: _____ / _____ / _____ Date you passed the pill: _____ / _____ / _____

For Female Patients:

First day of last menstrual period: _____ / _____ / _____ Post-menopausal? YES NO

Are you pregnant or experiencing a late menstrual period? YES NO

Are you taking oral contraceptives or receiving hormonal treatment? YES NO

Are you taking any type of fertility medication or having fertility treatments? YES NO

If yes, please describe: _____

Are you currently breastfeeding? YES NO

IT IS THE STANDARD POLICY AT BORLAND GROOVER THAT ALL FEMALE PATIENTS OF CHILD BEARING AGE (WHO HAVE NOT HAD A HYSTERECTOMY) WILL PROVIDE A URINE SAMPLE FOR PREGNANCY TESTING PRIOR TO THE START OF THE MRI PROCEDURE.

**BORLAND GROOVER IMAGING CENTER
MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS**

Name (First, Middle Initial, Last) _____ Date of Birth _____ / _____ / _____



WARNING: Certain implants, devices, or objects may be hazardous to your 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 questions or concerns 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.

Before entering the MR environment or MR system room, you must remove ALL metallic objects including hearing aids, dentures, partial plates, keys, 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 with the MRI Technologist or Radiologist if you have any questions or concerns 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.

Please indicate if you have any of the following:

- YES NO Aneurysm clip(s) and/or coils
- YES NO Cardiac pacemaker
- YES NO Implanted cardioverter defibrillator (ICD)
- YES NO Electronic implant or device
- YES NO Neurostimulator or deep brain stimulator
- YES NO Spinal cord, bone, gastric or bladder stimulator
- YES NO Feeding tube with mercury tip
- YES NO Organ transplant or on waiting list (indicate organ) _____
- YES NO Cochlear, otologic, stapes or other ear implant
- YES NO Insulin or other infusion pump
- YES NO Implanted drug infusion device or pain pump
- YES NO Any type of prosthesis (eye, penile, limb etc.)
- YES NO Removable glucose monitoring device or medication patch on your skin
- YES NO Eyelid spring/wire or glaucoma shunt
- YES NO Metallic stent, filter, coil, shunt (spinal or intra-ventricular)
- YES NO Vascular access port and/or catheter
- YES NO Radiation seeds or implants
- YES NO Wire mesh implant
- YES NO Swan-Ganz or thermodilution catheter
- 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 Body tattoo or permanent makeup
- YES NO Body piercing jewelry
- YES NO Hearing aid
- YES NO Kidney disease/impaired renal or kidney function
- YES NO Diabetes
- YES NO High blood pressure / hypertension
- YES NO Dialysis
- YES NO Kidney surgery or only 1 kidney
- YES NO Gout
- YES NO Proteinuria (protein in your urine)
- YES NO IV injection of contrast in the past month
- YES NO Asthma, emphysema or COPD (please circle)

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 have been offered a copy of the contrast medication guide. I have 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 me, 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 _____ / _____ / _____

Form completed by: (please circle) PATIENT RELATIVE OTHER (print name) _____

Form information reviewed MRI Technologist (signature) _____