UTHealth The University of Texas Health Science Center at Houston | McGovern Medical School

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

PLEASE USE BLACK OR BLUE INK

Date _____ Time _____ (scheduled) Study Number(s) _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

Date of Birth _____ Male ❒ Female ❒
month day year

Body Part to be examined _____ Referring Physician _____

Tech Notes: _____

_____ Contrast _____

Have you ever had any surgery or procedure on the part of the body we're scanning today? ❒ No ❒ Yes
If yes, please indicate the date and type of surgery: _____
_____

Have you ever had any other surgery or procedure that left any implanted metallic or electronic devices? ❒ No ❒ Yes
If yes, please indicate the date and type of surgery: _____
_____

Have you ever had an MRI before? If yes, body part? _____ ❒ No ❒ Yes
If yes, location and date? (month/year) _____

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

Have you had any other diagnostic imaging studies on the part of the body we're scanning today? ❒ No ❒ Yes
X-ray When _____ Where _____
CAT Scan (CT) When _____ Where _____
Bone Scan When _____ Where _____

Have you had an injury to the eye involving metallic objects/fragments (metallic slivers, shavings, etc.)? ❒ No ❒ Yes
If yes, please describe: _____

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

Are you currently taking or have you recently taken any medication or drug? ❒ No ❒ Yes
If yes, please list: _____

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

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

Do you have any renal (kidney) disease, reduced renal function or renal failure? ❒ No ❒ Yes

Do you have any known personal history of Cancer? ❒ No ❒ Yes
If yes, please list: _____

Have you ever undergone chemo- or radiation therapy? ❒ No ❒ Yes
If yes, when & what body part (radiation): _____

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

Are you currently a smoker or have you smoked regularly in the past? ❒ No ❒ Yes
If yes, how many packs per day _____ and for how long _____

For female patients:

Date of last menstrual period: _____/_____/_____ Postmenopausal? ❒ No ❒ Yes

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

Are you currently breastfeeding? ❒ No ❒ Yes

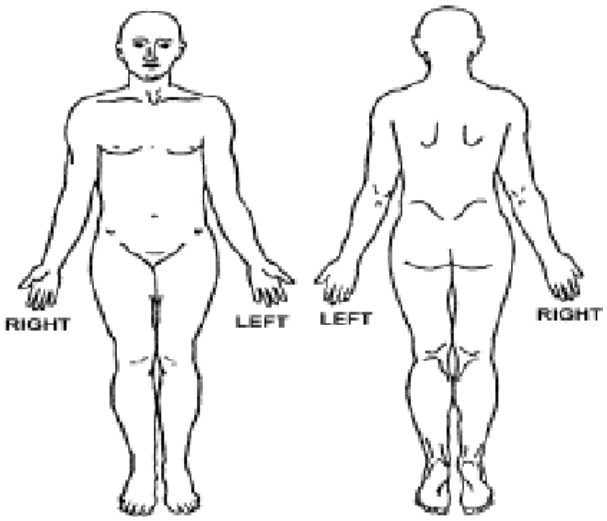
MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

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 indicate if you have any of the following:

Aneurysm clip(s)	❒ No ❒ Yes
Cardiac pacemaker	❒ No ❒ Yes
Implanted cardioverter defibrillator (ICD)	❒ No ❒ Yes
Any other electronic implant or device	❒ No ❒ Yes
Magnetically-activated implant or device	❒ No ❒ Yes
Neurostimulation system	❒ No ❒ Yes
Spinal cord stimulator	❒ No ❒ Yes
Internal electrodes or wires	❒ No ❒ Yes
Bone growth/bone fusion stimulator	❒ No ❒ Yes
Cochlear, otologic, or other ear implant	❒ No ❒ Yes
Insulin or other infusion pump	❒ No ❒ Yes
Implanted drug infusion device	❒ No ❒ Yes
Any type of prosthesis (eye, penile, etc.)	❒ No ❒ Yes
Heart valve prosthesis	❒ No ❒ Yes
Eyelid spring or wire	❒ No ❒ Yes
Artificial or prosthetic limb	❒ No ❒ Yes
Metallic stent, filter, or coil	❒ No ❒ Yes
Shunt (spinal or intraventricular)	❒ No ❒ Yes
Vascular access port and/or catheter	❒ No ❒ Yes
Radiation seeds or implants	❒ No ❒ Yes
Swan-Ganz or thermodilution catheter	❒ No ❒ Yes
Medication patch (Nicotine, Nitroglycerine)	❒ No ❒ Yes
Any metallic fragment or foreign body	❒ No ❒ Yes
Wire mesh implant	❒ No ❒ Yes
Tissue expander (e.g., breast)	❒ No ❒ Yes
Surgical staples, clips, or metallic sutures	❒ No ❒ Yes
Where: _____	
Joint replacement (hip, knee, etc.)	❒ No ❒ Yes
Bone/joint pin, screw, nail, wire, plate, etc.	❒ No ❒ Yes
IUD, diaphragm, or pessary	❒ No ❒ Yes
Dentures or partial plates	❒ No ❒ Yes
Tattoo or permanent makeup	❒ No ❒ Yes
Body piercing jewelry	❒ No ❒ Yes
Hearing aid *(Remove before entering MRI room)*	❒ No ❒ Yes
Other implant _____	❒ No ❒ Yes
Breathing problem or motion disorder	❒ No ❒ Yes
Claustrophobia	❒ No ❒ Yes

Please mark on the figure(s) below the location of any area of pain related to the exam you are having today



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, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & 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 will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.
NOTE: Notify MR staff immediately if "YES" to any of the above.

I attest that the above information is correct to the best of my knowledge. I 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.

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

Form Completed By: ❒ Patient ❒ Relative ❒ Nurse _____ _____
Print name Relationship to patient

Form Information Reviewed By: _____ _____
Print name Signature

❒ MRI Technologist ❒ MRI Tech Assistant ❒ Radiologist ❒ Other _____