Welcome to Magnetic Resonance Imaging (MRI) in Radiology! MRI uses a strong magnetic field and radiowaves to make images. We must ask each patient many questions to determine if the exam can be completed safely. Each question must be answered by filling in the blanks and checking the correct box where needed so we can provide the best possible care. After the questionnaire is completed, someone from our staff will review all of the responses and you will have the opportunity to ask questions before the exam.

**WARNING – THE PATIENT MUST BE ESCORTED BY MRI STAFF AT ALL TIMES!**

**Name of Person Completing Form and Relation to Patient**

Please describe the reason your doctor referred you for an MRI exam. Please list any problems, pain, and/or other symptoms you are having.

**How long have you had this problem/pain?**

Have you ever had an injury to the area that is to be examined? Please use the diagram to mark the exact site of pain/injury. Describe your injury.

- □ YES  □ NO □ Have you had any prior radiology exams related to this area (such as x-ray, CT, Nuclear Medicine, PET, ultrasound or MRI)? If YES, when and where were they performed?

- □ YES  □ NO □ Have you ever had cancer? If yes, what type?

- □ YES  □ NO □ Did you have radiation treatment? If yes, when and to what part of your body?

- □ YES  □ NO □ Have you ever had chemotherapy?

Please list any surgeries and the dates.

- □ YES  □ NO □ Have you ever been on dialysis or are you currently on dialysis?

- □ YES  □ NO □ Do you have diabetes?

- □ YES  □ NO □ Do you have high blood pressure that requires medication?

- □ YES  □ NO □ Have you ever been treated for kidney disease, kidney failure, or had a kidney removed?

- □ YES  □ NO □ Do you have any allergies? If YES, please describe.

As a part of the MRI exam, the radiologist may deem it necessary to give you an IV injection of a contrast agent containing gadolinium. Minor reactions (such as headache, nausea, or hives) to these agents may occur in less than 1% of the patients. However, serious or life threatening reactions, including (but not limited to) nephrogenic systemic fibrosis (NSF) have been reported in patients receiving these contrast agents.

- □ YES  □ NO □ Have you ever had an MRI exam with contrast?

- □ YES  □ NO □ Have you ever had a reaction to the MRI contrast? If yes, describe: ________________________________
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The MRI magnet is always on! Before entering the MR system room, the PATIENT 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, and clothing with metallic threads. The patient will be provided a locked cabinet to store safely personal belongings during the exam. The patient will also be provided hearing protection to use during the exam.

Patient Weight (lbs) □ Stated □ Actual Patient Height

The following items can interfere with MRI and some can be hazardous to the body while in the MRI scanner. Please indicate if you have any of these items anywhere in or on your body.

YES NO
□ □ Hearing aid(s), ear prosthesis, cochlear implant or other implant
□ □ Implant drug pump (e.g. for insulin or other)
□ □ Pacemaker, wires, or defibrillator (ICD)
□ □ Brain /aneurysm clip or coil
□ □ Stent, coil, filter, or wire in blood vessel
□ □ Surgical (wire) mesh implant
□ □ Electrodes or neurostimulator (TENS unit)
□ □ Artificial heart valve
□ □ Implanted catheter, tube, shunt , or wires
□ □ Tissue expanders (e.g. breast)
□ □ Have you ever had brain surgery?
□ □ Have you ever been hit in the face, eye or body with a piece of metal (e.g. shrapnel, metal shavings, bullets, BB’s, or other)?
□ □ Have you ever had metal removed from your eye(s)?
□ □ Have you ever had eye surgery (for retinal detachment or glaucoma, have eyelid spring or wire placed)?
□ □ Have you had upper endoscopy or colonoscopy in past month? If YES, when? ________________
□ □ If yes, was polyp removed or clip placed?
□ □ FEMALE patients: Are you pregnant, possibly pregnant, and/or breastfeeding?

PATIENT ATTESTATION: I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of both pages of this form and have had the opportunity to ask questions regarding the information and the procedure. Because hearing protection is required, it has been provided to me by the staff member prior to starting the MRI exam.

Patient or Responsible Person Signature ___________________________ Date/Time ___________________________

If limited English proficient or hearing impaired, offer interpreter at no additional cost:
□ Interpreter Accepted ___________________________ □ Interpreter Refused ____________
(“Name/Number of Person/Services Chosen/Used) ________________

FOR MRI STAFF USE ONLY

□ Yes □ No Patient screened with x-rays or CT topogram? If YES, Approving MR Radiologist

□ i-STAT □ Previous lab results
□ Creatinine (mg/dL) □ eGFR □ Date □ Approving MR Radiologist (if applicable)
□ MultiHance □ Evist □ Ablavar
□ Magnevist □ Gadavist
Amount (ml) □ IV Size (G) □ IV Started by
□ Lot # □ Location □ Time

TECHNOLOGIST ATTESTATION: My signature confirms that instructions and education have been provided to the patient regarding the MRI exam, that blood chemistry was checked per guidelines if contrast required, and that hearing protection was provided. Furthermore, it confirms that I have verified to the best of my knowledge all screening information prior to performing the exam.

Staff Signature ___________________________ Date/Time ___________________________

MRI Technologist Signature (REQUIRED) ___________________________ Date/Time ___________________________

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Patient Name: ___________________________ DOB: ____________ Or label
75701 R 6/24/2015 Name / MR # / Label