THE IMAGING CENTER

Scheduling 970-282-2912 • Main: 970-282-2900 • Fax 970-282-9800

MRI SCREENING FORM

Patient Identification

Name____________________________ **Date of Birth** __________

Weight__________ **Height** __________ ☐ **Male** ☐ **Female**

Please indicate if you have any of the following:

	Answer	Comments
1. Do you have or have you ever had a pacemaker, pacing wires, implanted cardioverter defibrillator (ICD) or artificial heart valve?	Yes / No	
If **YES**, Add comment, make and model #, etc. if possible.		
2. Have you had any surgery anywhere in your body? (eyes, ears, head, spine, arms, hands, neck, chest, abdomen, legs, ankles, etc.)	Yes / No	
If **YES**, What type of surgery, metal, or prosthesis? (Add comment, make/model #, etc. if possible)		
3. Have you had any metal or shrapnel in your body or eyes? (plates, screws, rods, metal shavings)	Yes / No	
If **YES**, where?		
4. Do you have any aneurysm clips, stents, coils, filters, devices or implants? (bone growth or spinal cord stimulator, neurostimulator)	Yes / No	
If **YES**, what type of item? (Add comment, make and model number, etc if possible)		
5. Do you have any gastrointestinal (GI) clips? (Olympus, LINX Device, etc.)	Yes / No	
6. Do you have an IUD, diaphragm, pessary, or breast tissue expander?	Yes / No	
7. Do you have any pumps, tubes, catheters, probes, arterial lines or intracranial pressure lines? If YES, please list.	Yes / No	
8. Do you have a shunt? (spinal or intraventricular)	Yes / No	
If **YES**, is the Shunt programmable?	Yes / No	
9. Do you have any body piercings, removable dental devices, temporary spacers, medication patches or hearing aids? (These will need to be removed.)	Yes / No	
10. Do you have any tattoos or permanent makeup?	Yes / No	
11. Are you pregnant or suspect you are pregnant?	Yes / No	
12. Are you currently breast feeding?	Yes / No	
13. Are you claustrophobic?	Yes / No	
14. Do you have any of the following conditions? (Circle all that apply)	None, CHF, Diabetes, High Blood Pressure, Kidney Disease	
If you circled **Kidney Disease,** which types apply?	Dialysis, Kidney Cancer, Kidney Surgery, Kidney Transplant, One Kidney, Other	
15. Are you allergic to any form of MRI contrast media (Gadolinium) or dye?	Yes / No	
16. Who answered the questions on this form?	Patient, Family Member, Other	
17. Who reviewed form with patient entering responses?	Nurse, MRI Tech, Other	

____________________________________ __________________

Patient Signature Date

____________________________________ __________________

Staff Signature Date

	Answer	Comments
Previous MRI exams (Dates/Location) ______________________________	Yes / No	____________
Have you experienced any problem related to a previous MRI examination or MR procedure?	Yes / No	
If **YES**, please describe? ______________________________		
Do you have any medication allergies?	Yes / No	
If **YES**, what kind? ______________________________		

Please briefly describe your symptoms:

____
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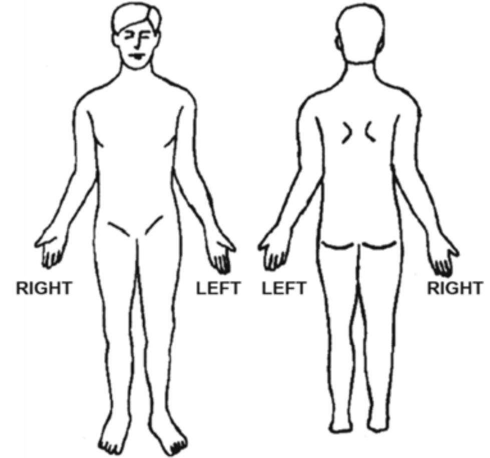
Please mark on the diagram the location of your symptoms:



IF YOU ARE HAVING IV CONTRAST, PLEASE READ AND SIGN

Your doctor has ordered an exam that requires a dye, that shows up on MRI, to be injected into a vein. Any intravenous procedure has risks involved, and successful IV insertion is not guaranteed. You have a right to refuse this injection, but this may provide less diagnostic information. Common risks of an IV include infiltration, infection, or inflammation of the vein or surrounding tissue. Some patients have a mild reaction to the dye, and may develop nausea, sneezing, flushing of the skin, and hives. Rarely (1 case in 1000) a more serious reaction to the dye can occur. The physicians and staff of The Imaging Center are trained to treat these reactions.

Patient / Representative Signatures: ______________________________ Date: ____________

Extremity MRI (ONLY) Questionnaire

What body part are we examining today? ______________________ ☐ Left ☐ Right

Estimated date of injury: ______________________

Do you have a follow-up appointment? _____ If so, when? ____________

Have you had previous arthroscopic or other surgery on this extremity? ☐ Yes ☐ No

What type of surgery?______________________

When was this surgery performed? Month _______ Year _________

Have you had previous dislocation of this joint? ☐ Yes ☐ No

When? Month _______ Year__________

What sports/activities aggravate your symptoms? ______________________

Do you have a lump or mass? ☐ Yes ☐ No

If Yes, where? ______________________

Have you had previous imaging of this extremity? (Cat Scan, MRI, X-ray, Etc.) ☐ Yes ☐ No

If Yes, When? Month________ Year_________

If Yes, Where? ______________________

The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices or objects. Therefore, all individuals are required to fill out this form BEFORE entering the MR system room. Be advised, the MR system magnet is ALWAYS on.