CATHOLIC HEALTH INITIATIVES®

Saint Clare's Health System

MRI SCREENING & SAFETY FORM

Today's Date _____ Height (feet/inches) _____ Weight (pounds) _____

First Name _____ Last Name _____

Date of Birth _____ Age _____ Gender: ☐ Male ☐ Female

List any problems or symptoms this test is evaluating: _____

ALLERGIES: Please list any allergies.

Drug	Describe Reaction

Do you have sensitivity to Latex? ☐ Yes ☐ No

Have you experienced any of the following? *(check all that apply)*

☐ Yes ☐ No Cardiac pacemaker or defibrillator

☐ Yes ☐ No Internal or external electrodes or wires

☐ Yes ☐ No Brain aneurysm clip(s) or coils

☐ Yes ☐ No Heart valve prosthesis

☐ Yes ☐ No Wires from a pacemaker or defibrillator

☐ Yes ☐ No Metallic stent, filter, coil, etc.

☐ Yes ☐ No Bladder Stimulator, Neurostimulator, TENS unit, or spinal stimulator

☐ Yes ☐ No Electrical Bone Growth Stimulator for spinal fusion

☐ Yes ☐ No Pump for insulin or other medication

☐ Yes ☐ No Medication patch (nicotine, nitroglycerine, etc.)

☐ Yes ☐ No Cochlear implant or other ear implant

☐ Yes ☐ No Hearing aid (remove before entering MRI room)

☐ Yes ☐ No Eye or eyelid implant or metal

☐ Yes ☐ No Shunt (spinal or intraventricular)

☐ Yes ☐ No Vascular access port or catheter

☐ Yes ☐ No Swan-Ganz or thermodilution catheter

☐ Yes ☐ No Artificial or prosthetic limb

☐ Yes ☐ No Joint replacement (hip, knee, etc.)

☐ Yes ☐ No Bone pin, screw, nail, wire, plate, etc.

☐ Yes ☐ No Orthopedic brace, splint or device

☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)

☐ Yes ☐ No Surgical staples, clips or metal sutures

☐ Yes ☐ No Radiation seeds or implants

☐ Yes ☐ No Wire mesh implant or tissue expander

☐ 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 Wound dressing containing silver

☐ Yes ☐ No Have you had a capsule (pill) endoscopy study in the last 30 days?

☐ Yes ☐ No Have you had clips placed during an endoscopy procedure?

☐ Yes ☐ No Have you ever been injured by a metallic object, such as a bullet, BB, shrapnel, buckshot, etc.)?

☐ Yes ☐ No Magnetically-activated implant or device

Any other metal in your body? _____

_____

Any other surgical implant? _____

_____

☐ Yes ☐ No Are you claustrophobic?

☐ Yes ☐ No Have you had any problem related to a previous MRI procedure?

☐ Yes ☐ No Do you have a history of kidney disease, hypertension or diabetes? If yes, which? ☐ Kidney Disease ☐ Hypertension ☐ Diabetes

☐ Yes ☐ No Do you have a history of liver transplant or liver failure? If so, which? ☐ Liver Transplant ☐ Liver Failure

☐ Yes ☐ No Do you receive dialysis? If so, when is next dialysis scheduled? _____

☐ Yes ☐ No Do you have a history of asthma, allergic reaction, respiratory disease or history of reaction to contrast medium (dye) used for an MRI, CT or X-ray examination?

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FOR FEMALE PATIENTS ONLY:

What was the date of your last menstrual period? _____

☐ Yes ☐ No	Are you pregnant?	☐ Yes ☐ No	Are you breast-feeding?
☐ Yes ☐ No	Receiving fertility medication or treatments?	☐ Yes ☐ No	Postmenopausal?
☐ Yes ☐ No	On oral contraceptives or hormonal treatment?	☐ Yes ☐ No	Experiencing a late period?

DO NOT ENTER MRI SCAN ROOM IF YOU HAVE ANY UNANSWERED QUESTIONS OR CONCERNS

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form, have had an opportunity to ask questions about the information on this form and the MRI procedure I am about to undergo, and have had all of my questions answered.

Patient Signature _____ Date _____

Form completed by: ☐ Patient

☐ Other Name _____

Relationship to Patient _____

Form reviewed by Technologist _____ Date _____ Time _____

Patient Clinical Symptoms	**Onset of Symptoms Date**

Relevant Surgery	**Date of Surgery**

History of Cancer: ☐ **Yes** ☐ **No** If Yes, type of cancer: _____ Diagnosis date: _____