190

LOURDES

Magnetic Resonance Imaging (MRI) Screening

Name:______________________________

DOB:________________ Age:_________

MR#:______________________________

Wt.:________ Procedure:____

Allergies to medications:____

Hx of Asthma? ☐ Yes ☐ No

The following items may interfere with a MRI and some can be potentially hazardous. Please indicate if you have the following:

Cardiac pacemaker/defibrillator ---------------------------- ☐Yes ☐No
Internal electrodes or wires --------------------------------- ☐Yes ☐No
Heart valve prosthesis --------------------------------------- ☐Yes ☐No
Brain aneurysm clip(s) -------------------------------------- ☐Yes ☐No
Intraventricular shunt -- ☐Yes ☐No
Implanted drug infusion device/insulin pump------------ ☐Yes ☐No
Bone growth stimulator / Neurostimulator (TENS unit) ☐Yes ☐No
Middle ear or Cochlear implant ---------------------------- ☐Yes ☐No
Any type of coil, filter, or stent – Type:_____________ ☐Yes ☐No
Pill Cam, Capsule Endoscopy device within 30 days ☐Yes ☐No
Eye prosthesis/eyelid spring--------------------------------- ☐Yes ☐No
Shrapnel, bullet(s), or BB's--------------------------------- ☐Yes ☐No

If you answered "Yes" to any of the above, please call --798-5023 **before** coming in for your appointment.

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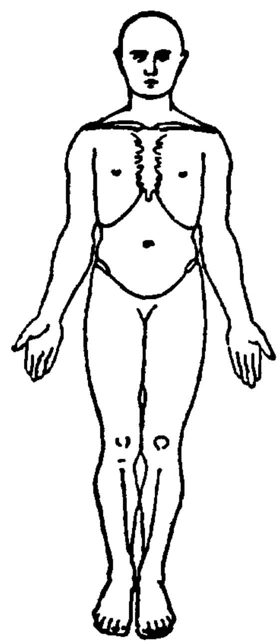
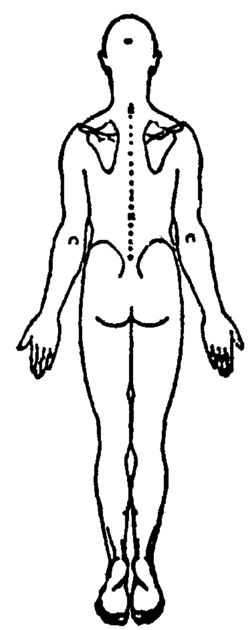
Hearing aid -- ☐Yes ☐No
Endoscopic Clip(s): Date placed__________________ ☐Yes ☐No
Any type of surgical clip/staple(s) or wire sutures ------ ☐Yes ☐No
Tissue expander (e.g. breast) ------------------------------- ☐Yes ☐No
Tattoos/tattooed eyeliner/permanent makeup ------------ ☐Yes ☐No
Pierced body parts -- ☐Yes ☐No
Nicotine/Pain or other patch w/adhesive backing ------- ☐Yes ☐No
Any other implanted item:_________________________ ☐Yes ☐No
Swan Ganz or Thermodilution catheter ------------------- ☐Yes ☐No
Artificial limb or joint -- ☐Yes ☐No
Orthopedic items (i.e.,pins, rods, screws, etc.) ----------- ☐Yes ☐No
Dentures/plate/retainer/any removable item ------------- ☐Yes ☐No
Dental braces/unremovable item --------------------------- ☐Yes ☐No
Males: Penile implant/prosthesis -------------------------- ☐Yes ☐No
Females: Are you pregnant or breastfeeding?----------- ☐Yes ☐No
Last menstrual period?__________________
Post menopausal? --------------------------------- ☐Yes ☐No
Diaphragm / IUD / Pessary -------------------- ☐Yes ☐No

Please mark the location of any metal inside your body:

Right **Left**



Left **Right**



LOURDES

MRI Screening

Name:_____

DOB:_____ Age:_____

MR#:_____

Please respond to the 8 questions below by circling either Yes or No.

1. Have you ever had a surgical procedure or operation of any kind? ☐Yes ☐No
   If yes, please list: _____
   _____
   _____
   _____
   _____
2. Have you ever worked in a machine shop or similar environment where you may have been subjected to small metal slivers injuring your eyes? ☐Yes ☐No
3. Do you have a History of Kidney Disease? ☐Yes* ☐No
4. Are you over 60 years of age? ☐Yes* ☐No
5. Are you currently on dialysis? ☐Yes* ☐No
6. Do you have diabetes? ☐Yes* ☐No
7. Have you had a liver transplant? ☐Yes* ☐No
8. Do you have hypertension (high blood pressure)? ☐Yes* ☐No
   (*GFR level _____ to be drawn within 6 weeks)

Radiology Staff Use Only:

☐ Injection Review: RN/Tech/Signature: _____Date/Time_____

GFR Level less than 40ml/min requires Radiologist Signature: _____ Date/Time_____

IMPORTANT INSTRUCTIONS

For your safety: <u>Before</u> entering the Magnetic Resonance (MR) environment or MR system room, let the MRI Technologist know if you have **<u>any of the items listed below on your body or in your pockets</u>:**

hearing aids	eyeglasses	hair pins/barrettes		wig
dentures	nail clipper	pocket knife		keys
safety pins	paper clips	belt	pens	tools
watch/jewelry	coins/money clip	magnetic strip cards		

partial plates
beeper/cell phone
body piercing jewelry
credit cards/bank cards

Please consult the MRI Technologist if you have any question or concern BEFORE you enter the MR system room.

All of the objects listed above (pertinent to the MRI) have been removed: ☐ Yes

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 _____

Form completed by: ☐ Patient ☐ Nurse ☐ Relative, if a relative: _____
Print Name & Relationship to Patient

Technologist Signature:_____ Date/Time_____

Print Form