



Please bring this form to your MRI appointment at
 9828 E. Shannon Woods Cir, Ste 100, Wichita, Ks, 67226
 P: 316-631-1600 // F: 316-631-1617

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Today's Date: ___ / ___ / ___ Chart # _____

Name _____ Age: _____ Height: _____ Weight: _____

Date of Birth: ___ / ___ / ___ Gender: M F AOA Physician: _____

Address: _____ Phone - home: _____ work: _____ cell: _____
 City: _____ State: _____ Zip: _____

Body Part to be examined: _____

Reason for MRI Symptoms: _____

Patient History

1. Have you had prior surgery on the area being scanned? No Yes
 If yes, please describe: _____

2. Have you had any prior diagnostic imaging study (MRI, CT, Ultrasound, X-rays) of the body part being scanned today? No Yes
 If yes, please list: Study _____ Date ___ / ___ / ___ Facility: _____
 Study _____ Date ___ / ___ / ___ Facility: _____

3. Have you ever had an injury to the eyes involving a metallic object or fragment (metallic slivers, shavings, foreign body, etc)? No Yes

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

5. Do you weigh more than 440 pounds? No Yes

For Female Patients:

6. Are you pregnant, or is there a possibility of you being pregnant? No Yes

7. Are you currently breastfeeding? (note esp if contrast study) No Yes

Note: See separate form if your MR procedure is a contrast study



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 concerns 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:

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

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

Please mark on the figures below the location of any implant or metal inside of / or on your body

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 questions or concerns **BEFORE** you enter the MR system room.

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 the person completing the form: _____ Date: _____
Signature

Form completed by: Patient Relative Nurse/Med Staff _____
Print name Relationship to patient

TO BE COMPLETED BY OFFICE STAFF

Form information reviewed by: _____
Print name Signature

MRI Technologist Nurse/Med Staff Radiologist Other _____