



MAGNETIC RESONANCE (MR) PROCEDURE SCREENING

PUT PATIENT LABEL HERE

Allentown Campus Bethlehem Campus Miners Memorial Campus Quakertown Campus Other _____

Patient D.O.B.: _____ Height: _____ Weight: _____ Body part to be examined: _____

Why are we doing the MRI exam today? What are your symptoms? _____

Referring Physician: _____

- 1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? NO YES
If yes, please list: _____
- 2. Have you had a prior diagnostic imaging study of the body part we are imaging today (MRI, CT, Ultrasound, X-ray, etc.)? NO YES
- 3. Do you have a history of renal/kidney disease (including one kidney, tumor or transplant)? NO YES
- 4. Do you have a history of liver disease (including tumor or transplant)? NO YES
- 5. Are you currently on dialysis? If yes, please check one: Hemo Peritoneal NO YES
- 6. Are you diabetic? NO YES
- 7. Do you have high blood pressure (hypertension)? NO YES
- 8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? NO YES
- 9. Have you experienced any problem related to a previous MRI examination or MR procedure? NO YES
If yes, please describe: _____
- 10. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, welding, grinding, etc.)? If yes, please describe: _____ NO YES
- 11. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? NO YES
If yes, please describe: _____
- 12. Are you wearing any medication patches? If yes, please remove prior to the MRI exam. NO YES
- 13. Are you allergic to any medication? NO YES
If yes, please list: _____
- 14. Do you have a history of cancer? NO YES
If yes, what type: _____


FOR FEMALE PATIENTS:

- 15. Date of last menstrual period: _____ Post menopausal? NO YES
- 16. Are you pregnant or experiencing a late menstrual period? NO YES
- 17. Are you taking oral contraceptives or receiving hormonal treatment? NO YES
- 18. Are you taking any type of fertility medication or having fertility treatments? NO YES
If yes, please describe: _____
- 19. Are you currently breastfeeding? NO YES



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	<input type="checkbox"/> YES <input type="checkbox"/> NO Cardiac Pacemaker	<input type="checkbox"/> YES <input type="checkbox"/> NO Swan-Ganz or Thermodilution Catheter
	<input type="checkbox"/> YES <input type="checkbox"/> NO Intracranial Pressure Monitor (BOLT)	<input type="checkbox"/> YES <input type="checkbox"/> NO Magnetically-Activated Implant Device/Prosthetic or Magnetic Dentures
	<input type="checkbox"/> YES <input type="checkbox"/> NO Implanted Cardioverter Defibrillator (ICD)	
	<input type="checkbox"/> YES <input type="checkbox"/> NO Temperature Foley	

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

- | | |
|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aneurysm clip(s) | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical staples, clips, or metallic sutures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Electronic Implant or Device | <input type="checkbox"/> Y <input type="checkbox"/> N Joint replacement (hip, knee, etc.) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Neurostimulation system or bone growth stimulator | <input type="checkbox"/> Y <input type="checkbox"/> N Bone/joint pin, screw, nail, wire, plate, etc. |
| <input type="checkbox"/> Y <input type="checkbox"/> N Internal electrodes or wires | <input type="checkbox"/> Y <input type="checkbox"/> N IUD, diaphragm, or pessary |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cochlear or other ear implant | <input type="checkbox"/> Y <input type="checkbox"/> N Dentures or partial plates |
| <input type="checkbox"/> Y <input type="checkbox"/> N Insulin or other drug infusion pump | <input type="checkbox"/> Y <input type="checkbox"/> N Tattoo or permanent makeup |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any type of prosthesis (eye, penile, etc.) | <input type="checkbox"/> Y <input type="checkbox"/> N Body piercing jewelry |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart valve prosthesis | <input type="checkbox"/> Y <input type="checkbox"/> N Claustrophobia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Eyelid spring or wire | <input type="checkbox"/> Y <input type="checkbox"/> N Latex Allergy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial or prosthetic limb | <input type="checkbox"/> Y <input type="checkbox"/> N Ventilator |
| <input type="checkbox"/> Y <input type="checkbox"/> N Metallic stent, filter or embolization coils | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Aid—Remove before entering MR system room |
| <input type="checkbox"/> Y <input type="checkbox"/> N Vascular access port and/or catheter | <input type="checkbox"/> Y <input type="checkbox"/> N Holter Monitor—Must be removed prior to exam |
| <input type="checkbox"/> Y <input type="checkbox"/> N Wire mesh implant | <input type="checkbox"/> Y <input type="checkbox"/> N EKG Patches—Must be removed prior to exam |
| <input type="checkbox"/> Y <input type="checkbox"/> N Tissue expander (e.g., breast) | <input type="checkbox"/> Y <input type="checkbox"/> N Shunt (spinal or intraventricular)?
Programmable—Needs XRay prior to exam |
| <input type="checkbox"/> Y <input type="checkbox"/> N Gastric/stomach clips from biopsy/lap banding | <input type="checkbox"/> Y <input type="checkbox"/> N Medication drips (if yes, please call MRI) |

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 question or concern BEFORE you enter the MR system room.

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 concern 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.

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

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: _____ Date ____/____/____
SIGNATURE

Form Completed By: Patient Relative Nurse _____
PRINT NAME RELATIONSHIP TO PATIENT

FOR MRI STAFF USE ONLY	
Form Information Reviewed By: _____	_____
<small>SIGNATURE</small>	<small>DATE</small>
_____	_____
<small>SIGNATURE</small>	<small>DATE</small>

