



MRI PATIENT SCREEN

Name: _____ DOB: _____ Height: _____ Weight: _____

Date: _____ Referring Doctor: _____ Radiology #: _____

Please read carefully and answer YES or NO to the following items:

Have you ever had an MRI before? Yes No
 Are you claustrophobic? Yes No
 Do you have allergies (including latex)? Yes No
 If yes, what? _____

DO YOU HAVE:

- Kidney Disease (Diabetic)	Yes	No
Dialysis	Yes	No
- Insulin pump (for diabetes)	Yes	No
- Transdermal patches	Yes	No
- Cardiac pacemaker or wires from a pacemaker	Yes	No
- Vascular clips: brain*, aortic, or carotid clips	Yes	No
- Prosthetic heart valve* (other heart surgery)	Yes	No
- Metal fragments (shrapnel, gunshot wound, welding or sheet metal injury), especially metal fragments near eye*	Yes	No
- Neurostimulators (TENS Unit)	Yes	No
- Shunt (ventricular or spinal)	Yes	No
Programmable	Yes	No
- Joint replacement, artificial limb	Yes	No
- Metal plates, pins, screws, spine rod, or other metal bone devices	Yes	No

- Wire sutures	Yes	No
- Hickman or Broviac catheter	Yes	No
- Eye Prosthesis	Yes	No
- Intrauterine Device (IUD)	Yes	No
- Middle ear prosthesis or cochlear implant	Yes	No
- Hearing Aid	Yes	No
- Dentures or braces	Yes	No
- Personal Cancer History	Yes	No
Type of Cancer	_____	
Year Diagnosed	_____	
Treatment: Chemo	Yes	No
Date of last treatment	_____	
Radiation	Yes	No
Date of last treatment	_____	

These particular items may not allow us to proceed with your examination

PLEASE ANSWER THE FOLLOWING:

- What body part are we imaging today? _____
- What are your symptoms? _____

- Duration of the symptoms _____
- Recent changes in symptoms (worsening or improvements) _____
- Do you have a mass in the area of concern? _____
- Injury to area (how long ago)? _____
- Have you had a steroid injection? _____
- Surgery to the area (what and when)? _____

- All previous surgeries: _____

- Previous tests in the past 6 months:
Test _____ Location _____

TECHNOLOGIST'S NOTES ONLY

Technologist Signature _____

Patient Signature _____ Date _____



Patient Name (PRINT) _____

I understand contrast material may be injected. The indications for and risks of the procedure known as an MRI were discussed with me. The risks were noted to include, but are not limited to, various types of allergic reactions to the intravenous contrast. Most of these reactions are minor, although they can be severe at times. On rare occasions, inflammation or infection at the site can occur and other more remote risks or consequences may also arise.

I have been advised that if further explanation is desired, I may ask additional questions to the staff to include any supervising radiologists and my referring physician.

Signature of patient or legal guardian

Date

Staff witness to signature

Date

FEMALE PATIENTS:

I AM PREGNANT

I AM NOT PREGNANT / LMP _____

I understand and hereby release all radiologists, respective staff and the facility thereof of any and all responsibility for any adverse reaction to myself and/or damage to my unborn fetus in the event I may be pregnant.

SIGNATURE _____