HIGHPOINT HEALTH

MRI SAFETY SCREENING FORM

Name:______________________________ Date:______________ Weight: ________lbs

Sex:___ Age:____ Date of Birth:________________ Ordering Doctor:__________________________ Outpatient:___ Inpatient:___

ATTENTION: **MRI PATIENTS AND ACCOMPANYING FAMILY MEMBERS: PATIENT SAFETY IS OUR PRIMARY CONCERN. WE MUST KNOW IF YOU HAVE METAL IN YOUR BODY. THE MRI ROOM CONTAINS A VERY STRONG MAGNETIC FIELD AND IS ALWAYS ON. THE FOLLOWING ITEMS MAY BE HAZARDOUS OR MAY INTERFERE WITH THE MRI EXAMINATION.**

PLEASE INDICATE BY *CHECKING* *YES* OR *NO* BOXES AND *CIRCLE* ANY OF THE FOLLOWING THAT YOU MAY HAVE:

☐ YES ☐ NO Aneurysm Clip (s)
☐ YES ☐ NO Cardiac Pacemaker or Cardiac Defibrillator
☐ YES ☐ NO Neurostimulator / Biostimulator / TENS Unit / Bone Stimulator (Type:____________________)
☐ YES ☐ NO Internal Electrodes or Wires (Pacing/VNS/DBS) (Type:__________________________________)
☐ YES ☐ NO Ear Implant / Cochlear Implant / Hearing Aid
☐ YES ☐ NO Vascular Access port
☐ YES ☐ NO Eye/Orbital Prosthesis or Eye Implant (Type:________________________________)
☐ YES ☐ NO Insulin Pump (Internal / External)
☐ YES ☐ NO Implanted Drug Infusion Device
☐ YES ☐ NO Swan-Ganz Catheter
☐ YES ☐ NO Any Type of Electronic or Mechanical Implant (Type:__________________________________)
☐ YES ☐ NO Medication Patch
☐ YES ☐ NO Heart Valve Prosthesis
☐ YES ☐ NO Intravascular Shunt

☐ YES ☐ NO Dentures / Partial Plates / Braces / Retainers
☐ YES ☐ NO IUD / Pessary / Diaphragm
☐ YES ☐ NO Penile Implant
☐ YES ☐ NO Wire Mesh
☐ YES ☐ NO Hair Piece / Wig / Hair Extensions / Hair Pins
☐ YES ☐ NO Tattooed Eyeliner / Body Piercing
☐ YES ☐ NO Any Type of Intravascular Coil, Filter or Stent (e.g., Gianturco Coil, Gunther IVC Filter, Palmas Stent etc.) (Type:____)
☐ YES ☐ NO Any Type of Implant Held in Place by a Magnet
☐ YES ☐ NO Any Type of Surgical Clips or Staples
☐ YES ☐ NO Halo Vest or Metallic Cervical Fixation Device
☐ YES ☐ NO Any Implanted Orthopedic items (i.e. Pins, Rods, Screws, Plates) (Other:_____________ ______________________________________)
☐ YES ☐ NO Artificial Limb or Joint__________________ ______________________________________
☐ YES ☐ NO Any other Implanted Item (s)_____________ ______________________________________)

☐ YES ☐ NO Have you ever had an injury by a metallic foreign body such as bullet, BB, or shrapnel?
☐ YES ☐ NO Have you ever had an injury to the eye involving foreign body such as metal slivers, shavings, etc?
☐ YES ☐ NO Do you or have you ever worked as a welder, grinder, or done any type of work that involved metal?
☐ YES ☐ NO Have you ever had a reaction to a contrast medium used during MRI or CT scan?
☐ YES ☐ NO Any drug allergies? Please List:____
☐ YES ☐ NO Are you or do you suspect that you may be pregnant? ☐ YES ☐ NO Are you breastfeeding?

A SMALL PERCENTAGE OF PATIENTS WITH TATTOOED EYELINER HAVE EXPERIENCED TRANSIENT SKIN IRRITATION IN ASSOCIATION WITH MRI. THEREFORE, YOU MUST DECIDE IF THIS SLIGHT RISK WARRANTS YOUR EXAMINATION. YOU MAY WANT TO DISCUSS THIS MATTER WITH YOUR REFERRING PHYSICIAN.

BEFORE ENTERING THE MRI SCAN ROOM, YOU MUST REMOVE ALL METALLIC OBJECTS (HEARING AIDS, CELL PHONES, KEYS, GLASSES, HAIR PINS, WATCH, CREDIT CARDS, PENS, POCKET KNIVES, MOST JEWELRY, ETC.). HOSPITAL CLOTHING WILL BE PROVIDED FOR YOU IF NECESSARY AND A LOCKER TO STORE YOUR VALUABLES.

WE STRONGLY RECOMMEND USING EARPLUGS PROVIDED FOR YOUR EXAMINATION SINCE SOME PATIENTS MAY FIND THE NOISE LEVELS UNACCEPTALBE AND MAY TEMPORARILY AFFECT HEARING.

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 AND I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS REGARDING THE INFORMATION ON THIS FORM.

SIGNATURE (PATIENT OR GUARDIAN):**____*****DATE*****:__________**

SIGNATURE (MD/RN/RT):**____ *****DATE:*** ___________

HIGHPOINT HEALTH

MRI SCREENING FORM

NAME:____ **DATE:**__________________

1. **Please indicate which symptoms you are having (specific to your MRI, today)? Exam**:__________________

_________**Headaches**

_________**Vision loss/Changes**

_________**Dizziness**

_________**Numbness/weakness in arms or legs(right/left)**

_________**Hearing loss (right/left)**

_________**Ringing in ears (right/left)**

_________**Change in bowel function**

_________**Change in bladder function**

_________**Lump or Mass**
Location:________________________________

_________**Swelling**
Location:________________________________

_________**Arm (right/left)**

_________**Leg (right/left)**

_________**Knee (right/left)**

_________**Lower back**

_________**Upper back**

_________**Neck**

_________**Abdomen**

_________**Foot (right/left)**

_________**Hand (right/left)**

_________**Shoulder (right/left)**

_________**Other**____

2. How long have you had these symptoms? ____
3. Is this the result of an injury? YES / NO If yes, describe: __________________________________
____
4. Have you (past/present) been diagnosed as having cancer? YES / NO
If yes, please state name of cancer and location in your body:____________________________________
5. Have you had chemotherapy? YES / NO If yes, when and how many treatments?___________________
6. Have you had radiation therapy? YES / NO If yes, when and what body part? _______________________
How many treatments?____
7. Please circle any personal history of: Diabetes/ Kidney Disease/ Liver Disease/ Anemia/ Seizures/ Asthma/ High Blood Pressure
8. Have you had an MRI before? YES / NO If yes, where/when?_________________________________
What body part?_________________
9. History of claustrophobia or anxiety? YES / NO
10. Have you had any previous surgeries? YES / NO If yes, what kind and approximate year? _____________
____
11. Any history of surgery on the body part to be scanned today? YES / NO
12. Did any of your surgeries involve leaving any metal in your body? YES / NO

** Your exam will take a while. Please use the restroom-now before having your scan **

Patient Signature: ____ **Date:** ______________________

For MRI Only: Gadolinium Dose:_________________

I have reviewed the Multihance contrast medication guide. ***Initials:***___________