Oregon Medical Group – Imaging
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MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date_____ /____/_____ Date of Birth ____/____/___
month day year month day year

Name:_____ _____ _____
Last name First name Middle Initial Height Weight

Reason for MRI and/or 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 indicate the date and type of surgery:
   Date ____/____/____ Date ____/____/_____
   Type of surgery _____ Type of surgery _____
2. Have you had a prior imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? No Yes
   If yes, please list: Body part Date Facility

MRI	_____	____/____/___	_____
CT/CAT Scan	_____	____/____/___	_____
X-Ray	_____	____/____/___	_____
Ultrasound	_____	____/____/___	_____
Nuclear Medicine	_____	____/____/___	_____
Other_____	_____	____/____/___	_____

3. Have you experienced any problem related to a previous MRI examination or MR No Yes
   If yes, please describe: _____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic shavings, foreign body, etc.)? No Yes
   If yes, please describe: _____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, No
   If yes, please describe: _____
6. Are you currently taking or have you recently taken any medication or drug? No Yes
   If yes, please list:_____
7. Are you allergic to any medication? No Yes
   If yes, please list:_____
8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a medium or dye used for an MRI, CT, or X-ray examination? No Yes
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? No Yes
   If yes, please describe: _____

For female patients:

10. Date of last menstrual period:____/____/___
11. Post menopausal? No Yes
12. Are you pregnant or experiencing a late menstrual period? No Yes
13. Are you taking oral contraceptives or receiving hormonal treatment? No Yes
14. Are you taking any type of fertility medication or having fertility treatments? No Yes
    If yes, please describe: _____
15. Are you currently breastfeeding? No Yes

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 MRITechnologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

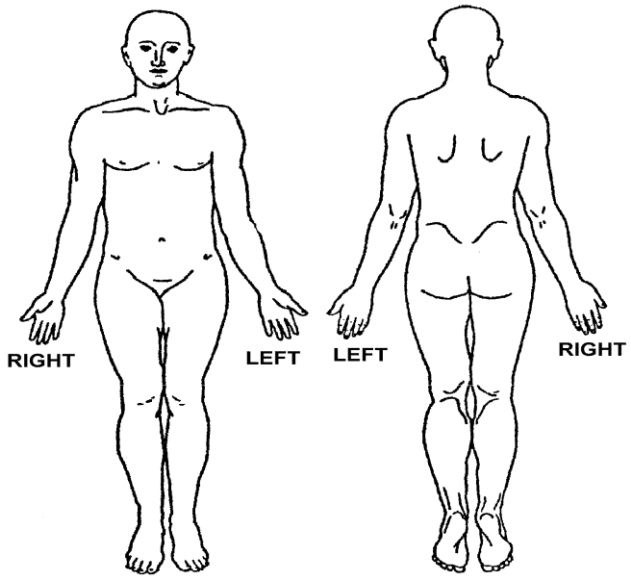
Please indicate if you have any of the following:

Yes	No	Aneurysm clip(s)
Yes	No	Cardiac pacemaker
Yes	No	Implanted cardioverter defibrillator (ICD)
Yes	No	Electronic implant or device
Yes	No	Magnetically-activated implant or device
Yes	No	Neurostimulation system
Yes	No	Spinal cord stimulator
Yes	No	Internal electrodes or wires
Yes	No	Bone growth/bone fusion stimulator
Yes	No	Cochlear, otologic, or other ear implant
Yes	No	Insulin or other infusion pump
Yes	No	Implanted drug infusion device
Yes	No	Any type of prosthesis (eye, penile, etc.)
Yes	No	Heart valve prosthesis
Yes	No	Eyelid spring or wire
Yes	No	Artificial or prosthetic limb
Yes	No	Metallic stent, filter, or coil
Yes	No	Shunt (spinal or intraventricular)
Yes	No	Vascular access port and/or catheter
Yes	No	Radiation seeds or implants
Yes	No	Swan-Ganz or thermodilution catheter
Yes	No	Medication patch (Nicotine, Nitroglycerine)
Yes	No	Any metallic fragment or foreign body
Yes	No	Wire mesh implant
Yes	No	Tissue expander (e.g., breast)
Yes	No	Surgical staples, clips, or metallic sutures
Yes	No	Joint replacement (hip, knee, etc.)
Yes	No	Bone/joint pin, screw, nail, wire, plate, etc.
Yes	No	IUD, diaphragm, or pessary
Yes	No	Dentures or partial plates
Yes	No	Tattoo or permanent makeup
Yes	No	Body piercing jewelry
Yes	No	Hearing aid

(Remove before entering MR system room)

Yes	No	Other implant _____
Yes	No	Breathing problem or motion disorder
Yes	No	Claustrophobia

Please mark on the figure(s) 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 question or concern BEFORE you enter the MR system room.

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.

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

MRI Technologist Notes:_