Goshen Hospital

MRI Screening form	SCRMRI

MRI SCREENING FORM FOR PATIENTS

Patient Name:_____ Date of Birth: _____
Date:_____ Weight: lbs:_____ Height:_____Age:_____ Sex:_____

This questionnaire is designed to assist us in determining if it is safe for you to undergo an MRI procedure. It is important that you answer all of the following questions. If you do not understand a question, please do not hesitate to ask for assistance. 06/30/16

Please indicate if you have any of the following: **Answer yes or no to ALL questions.**

Any yes or no to all questions.

Yes	No		Yes	No	
		Cardiac Pacemaker or Defibrillator			Dentures or partials, tattoo or permanent makeup, body piercing jewelry.
		Aneurysm clip(brain or abdominal)			Joint Replacement
		Electronic, magnetically-activated implant or device, internal electrodes or wires			
		Neurostimulator, spinal cord, bone growth/bone fusion stimulator/system			Shunt(spinal or intraventricular), vascular access port
		Cochlear, otology, or other ear implant, hearing aids			Any type of prosthesis (heart valve, eye, eyelid spring/wire, limb, penile…)
		Swan-Ganz or thermodilution catheter			Medication patch (Nicotine or Nitro)
		Tissue expander (Breast)			Insulin, drug or other implanted pump
		Stent, filter or coil			Breathing problems
		Hair weaves, Extentions, Wigs or Hair Acc…			Magnetic Eyelashes
		Eye Surgery			Claustrophobia
		IUD, diaphragm, or pessary			Cancer Type: When:

1. Please list **ALL** surgeries and year done? _____

   _____

   _____

   _____

2. List the most recent date and facility of any x-rays, CT, US, PET or MRI scans of area we are scanning today.
   Date:_____ Location:_____

   Date:_____ Location:_____

3. Have you had an injury to the body or eye involving a metallic object or fragment
   No___ Yes___
   If yes, please describe. _____

   Did you have it removed by a physician? No___ Yes___

4. Is there a chance you might be pregnant? Last menstrual period?_____NA No Yes

5. Have you had the following? Stroke_____ Seizure _____

Goshen Hospital

MRI Screening form

SCRMRI

6. Why are you having this exam today? Injury? Y N Duration of symptoms? _____

_____

_____

_____

7. Are you allergic to medications including Contrast media? Yes No
   If yes, Please list: _____

8. Do you have any of the following health problems?

   Diabetes Kidney Disease Heart Problems Multiple Myeloma Kidney Removed

9. Are you currently taking the chemotherapy drug Hydroxyurea? Yes No

10. Please list all prescribed medications you are taking—We do not need to know the dose:

I certify that I have read and understand the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform Goshen Hospital of any metal fragments and/or devices that may be in my body and that by failing to do so may cause serious bodily injury or be life threatening. **I agree that I have discussed all surgery and implant information with the MRI Tech/Assistant and elect to proceed with the MRI.** I am aware of the consequences and risks related to tattoos and/or piercings and I am assuming these risks, and elect to proceed with the MRI. I agree to release Goshen Hospital from any and all liability for any injury.

_____	_____	_____
Patient or Legal Representative Signature	Print Name and Authority (if legal representative)	Date
_____	_____	_____
Witness/Interpreter	Print Name	Date
_____	_____	_____
MRI Technologist Signature	Print name and title	Date

MRI Staff Only(Contrast Form)
I acknowledge that I have read and understand the "Medication Guide Dotarem" form. Patient or legal guardian signature _____ Relationship to Patient_____ IV by: Initials:_____Sticks/Site:_____Lot/Exp:_____ Amount used:_____ Amount Wasted: _____
MRI Staff only(Piercing)
I acknowledge that I have read and understand the "Piercing" form. Patient or legal guardian signature _____ Relationship to Patient_____

Updated 11/2020