Radiology Department
MRI Patient Assessment, Screening and Order Form

Referring Clinic: _____

Exam Requested: _____ Date/Time of Exam: _____

Referring Physician: _____ Clinical Indication for Exam _____

Patient Height _____ Weight _____ _____

HCG Results (HCG Test to be Performed Day of Scan) _____

MRI CANNOT be performed if "Yes" is answered to triple asterisked (***) questions.
All "Yes" single asterisked (*) are to be referred to the radiologist. For an all inclusive list of contraindications visit www.mrisafety.com

Please list all previous surgeries to any body part _____
_____
_____
_____
_____

***Pacemaker or Pacemaker wires**	Yes	No
***Small Bowel Endoscopy Capsule	Yes	No
***Implanted Neurostimulators	Yes	No
***Implanted Cardiac Defibrillator**	Yes	No
** Pregnant	Yes	No
** Breast Feeding	Yes	No
* Carotid Clips	Yes	No
* Artificial Heart Valves	Yes	No
* **Heart Stents**	**Yes**	**No**
If yes to previous two questions need -		
Date: _____ **Make:** _____		
Model: _____		
* History of severe hepatic disease/liver transplant/pending Liver transplant (no contrast for perioperative liver pts.)	Yes	No
* Hypertension	Yes	No
* **Aneurysm/Vascular Clips/Grafts/Stents/Repair**	Yes	No
If yes, list _____		
* Surgical Clips	Yes	No
* **Infusion Pump**	Yes	No
* Allergies to IV dye, seafood, shellfish	Yes	No
* Dialysis/Renal Failure/Renal Insufficiency	Yes	No
* Metallic Foreign Body (Gun shot wound, metal shavings in eye, retinal buckle, etc.)	Yes	No
If yes, explain _____		
* Prior Ear or Brain Surgery	Yes	No
If yes, explain: _____		

* Diabetes	Yes	No
* Diabetic Pump	Yes	No
* Wound Dressing (i.e. Acticoat 7)	Yes	No
* Breast Tissue Expanders	Yes	No
Asthma	Yes	No
Irregular Heartbeat	Yes	No
Electrodes/Neurostimulators (tens-unit)	Yes	No
Vena Cava Umbrella Filter	Yes	No
Latex Allergies	Yes	No
History of Cancer	Yes	No
Metallic Implant /Prosthesis/Ortho Devices	Yes	No
Removable Hearing Aid	Yes	No
Epilepsy (Seizures)	Yes	No
Uncooperative or Disoriented	Yes	No
Claustrophobia	Yes	No
Unable to Hold Still	Yes	No
Braces	Yes	No
Removable Dental Work	Yes	No
Glitter Eye makeup	Yes	No
Tattoos and/or Body Piercing	Yes	No
Medication Skin Patches (Nitroglycerine, stop smoking, pain, birth control, etc.)	Yes	No
Any history with a * or ** approved by radiologist/nephrologists	Yes	No

If no, explain: _____
_____
_____
_____
_____

Patient Signature: _____ Date: _____
(Parent or Guardian)

Interviewer's Signature: _____ Date: _____

"To Respect, To Heal, To Console"

MRI PATIENT ASSESSMENT, SCREENING & ORDER FORM

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PATIENT INFORMATION