ORLANDO HEALTH® | Imaging Centers

LINE UP PATIENT I.D. LABEL HERE

MRI SCREENING AND PATIENT HISTORY

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI procedure. The MRI system has a very strong magnetic field that may be hazardous to individuals entering the MRI environment if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. Please consult the MRI technologist if you have any questions or concerns regarding an implant, device or object BEFORE you enter the MRI room. The MRI system magnet is ALWAYS on.

IMPORTANT INSTRUCTIONS - Before entering the MRI environment or MRI 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, paper-clips, money-clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fastener, clothing with metallic threads and personal wheelchairs or stretchers.

You may be advised or required to wear earplugs or other hearing protection during the MRI procedure to prevent possible problems or hazards related to acoustic noise.

Weight _____ Height _____ Does the patient have an IV? ❑ Yes ❑ No

Does the patient have Claustrophobia, Anxiety or Emotional Distress? ❑ Yes ❑ No

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Cardiac pacemaker	❑ Yes	❑ No	Electronic implant or other implanted device	❑ Yes	❑ No
Aneurysm clip(s)	❑ Yes	❑ No	Had a piece of metal removed from your eye	❑ Yes	❑ No
Spinal cord stimulator	❑ Yes	❑ No	Heart valve prosthesis	❑ Yes	❑ No
Neurostimulation system	❑ Yes	❑ No	Shunt (spinal or intraventricular)	❑ Yes	❑ No
			Radiation seeds or implants	❑ Yes	❑ No
Implanted cardioverter defibrillator (ICD)	❑ Yes	❑ No	Medication patch (Nicotine, Nitroglycerin,	❑ Yes	❑ No
Magnetically-activated implant or device	❑ Yes	❑ No	Contraceptive)		
Bone growth/bone fusion stimulator	❑ Yes	❑ No	Surgical staples, clips, or metallic sutures	❑ Yes	❑ No
Internal electrodes or wires	❑ Yes	❑ No	Orthopedic bone/joint pin, screw, nail, wire, plate	❑ Yes	❑ No
Implanted drug/pain medication infusion device	❑ Yes	❑ No	Joint replacement (hip, knee, etc.)	❑ Yes	❑ No
Insulin or other infusion pump	❑ Yes	❑ No	Tattoo or permanent makeup	❑ Yes	❑ No
Tissue expander (e.g., breast)	❑ Yes	❑ No	Hearing aid (Remove before entering MRI room)	❑ Yes	❑ No
Any type of prosthesis (eye, penile, etc.)	❑ Yes	❑ No	Artificial or prosthetic limb	❑ Yes	❑ No
			Worked as a machinist, welder, metal worker	❑ Yes	❑ No
Eyelid spring or wire	❑ Yes	❑ No	Linx Reflux Management System	❑ Yes	❑ No
Metallic stent, filter, or coil in a blood vessel	❑ Yes	❑ No	(for Barretts Esophagus and Severe Reflux)		
(If yes, date of placement) _____			Colonoscopy clips yes/no	❑ Yes	❑ No
Cochlear, otologic, or other ear implant	❑ Yes	❑ No	Wire mesh implant	❑ Yes	❑ No
Swan-Ganz or thermodilution catheter	❑ Yes	❑ No	IUD, diaphragm or pessary	❑ Yes	❑ No
			Currently breast-feeding	❑ Yes	❑ No
Other Implants _____	❑ Yes	❑ No	Current or previous history of dialysis	❑ Yes	❑ No
Any metallic fragment or foreign body (Bullets, Shrapnel etc.)	❑ Yes	❑ No	Previous history of renal failure/insufficiency, renal	❑ Yes	❑ No
Dentures or partial plates	❑ Yes	❑ No	disease, or diabetes		
Body Piercing Jewelry	❑ Yes	❑ No	Recent blood test for Creatinine level?	❑ Yes	❑ No
Pregnant	❑ Yes	❑ No	If yes, results: Date collected _____		

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 MRI procedure that I am about to undergo.

_____ _____ ____/____/____ _____

Signature of Person Completing Form Printed Name Date Time

Screening Form Completed By: ❑ Patient ❑ Relative ❑ Nurse ❑ Other _____

I _____ MRI technologist have screened the patient according to the MRI patient safety policy and guidelines set forth by the department. This patient is approved ❑ yes ❑ no to enter the MRI room on Date _____ . If no, explanation _____ .

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Does the patient have any Allergies? ❑ Yes ❑ No Calculated GFR _____

If yes, please list: _____

Previous history of reaction to contrast or dye material? ❑ Yes ❑ No

Reason for MRI and /or symptoms: _____

_____

_____

_____

How Long? _____ ❑ Gradual or ❑ Sudden onset?

Have you had surgery on the body part being examined?

❑ Yes ❑ No If yes, when? _____

What was done? _____

Any other major illness/injury unrelated to the body part being examined today? ❑ Yes ❑ No

If yes, explain: _____

History of cancer? ❑ Yes ❑ No

If yes, what type? _____

When? _____ Current Status: _____

Has the patient had a prior imaging examination of the body part being examined today? (i.e., MRI, CT, X-Ray, Ultrasound, Bone-scan, etc) ❑ Yes ❑ No

Where _____

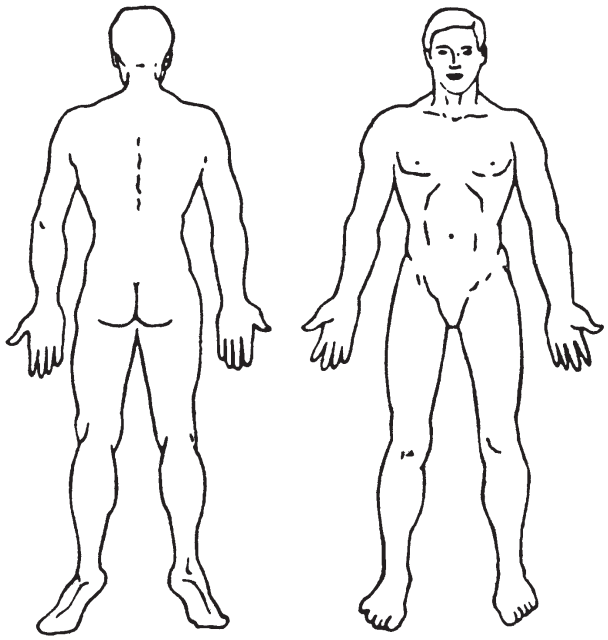
When _____ Results _____

Has the patient had prior arthroscopy, angiography/angiogram, catheter (i.e. heart) or needle localization/needle injection procedure? ❑ Yes ❑ No

Body part _____

When _____ Results _____

Please mark on the figure below the location of pain and/or symptoms



Technologist Comments:

INTERPRETER ONLY	PATIENT ASSISTANCE PROVIDED
Interpreter Name: _____	❑ Reader for Visually Impaired
Agency & I.D.#: _____	Name: _____
Team Member Name & I.D.#: _____	
❑ Video Remote ❑ Tel ❑ In person Language: _____	