Name_____

Doctor's name_____

Patient Weight_____ Age_____

1. Have you ever had surgery in the area we are imaging today? ☐ No ☐ Yes
   If yes, please explain _____
_____
_____

2. Have you had any previous studies of the area being imaged today? ☐ No ☐ Yes

	DATE	**FACILITY LOCATION**
MRI	_____/ _____/_____	_____
CT/CAT Scan	_____/ _____/_____	_____
X-Ray	_____/ _____/_____	_____
Nuclear Medicine	_____/ _____/_____	_____
Ultrasound	_____/ _____/_____	_____

4. Do you have a Cardiac Pacemaker? ☐ No ☐ Yes
5. Do you have an Implanted Cardiac Defibrillator? ☐ No ☐ Yes
6. Do you have an Aneurysm Clip(s)? ☐ No ☐ Yes
7. Have you ever had metal in your eyes from grinding or lathe working? ☐ No ☐ Yes
8. Are you pregnant or breastfeeding? ☐ No ☐ Yes
9. Do you have a history of kidney or blood disease? ☐ No ☐ Yes
10. Please list all **medications** that you're currently taking:_____
_____
_____

11. Occasionally we must use a "dye" or contrast to enhance lesions or surgical scar tissue. This is an IV injection that aids in your diagnosis. IT IS NOT THE SAME AS USED IN X-RAY OR CT. Would you consent to this injection if necessary? ☐ No ☐ Yes

Signature _____
Contrast = Gadolinium _____ **Amount** _____**Tech Initials** _____

12. Do you have another appointment scheduled with your Doctor? ☐ No ☐ Yes
    When?_____

Please list your symptoms that brought you here today.

_____
_____
_____

Portneuf MEDICAL CENTER

Pre-MRI Screening Form

DOC NO RA00111 (3/7/11) RK

Patient Label

Do Not Place Below This Line.

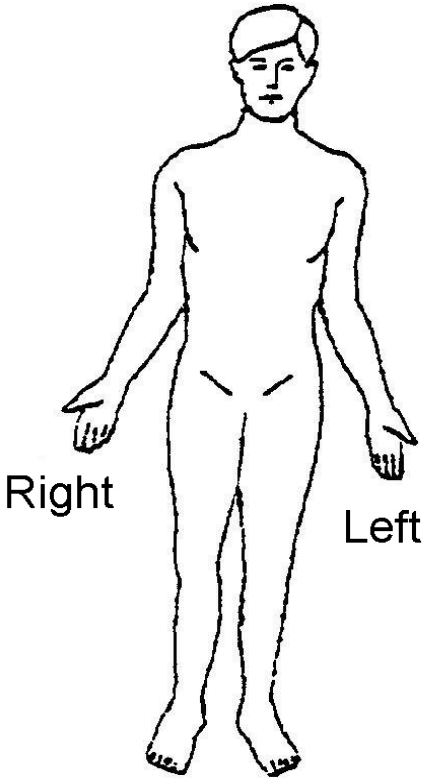
Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following. Do you have any of the following:

☐ **YES**	☐ **NO**	**Carotid Artery Vascular clamp**
☐ **YES**	☐ **NO**	**Neurostimulator**
☐ **YES**	☐ **NO**	**Insulin or Infusion pump**
☐ **YES**	☐ **NO**	**Implanted drug infusion device**
☐ **YES**	☐ **NO**	**Bone growth/fusion stimulator**
☐ **YES**	☐ **NO**	**Cochlear, otologic, or ear implant**
☐ YES	☐ NO	Internal pacing wires
☐ YES	☐ NO	Any type of prosthesis (eye, Penile, etc.)
☐ YES	☐ NO	Heart Valve prosthesis
☐ YES	☐ NO	Artificial limb or joint
☐ YES	☐ NO	Electrodes (on body, head or brain)
☐ YES	☐ NO	Intravascular stents, filters or coils
☐ YES	☐ NO	Shunt (spinal or intraventricular)
☐ YES	☐ NO	Vascular access port and/or catheter
☐ YES	☐ NO	Swan-Ganz catheter
☐ YES	☐ NO	Any implant held in place by a magnet
☐ YES	☐ NO	Transdermal delivery system (Nitro)
☐ YES	☐ NO	IUD or diaphragm
☐ YES	☐ NO	Tattooed makeup (eyeliner, lips. Etc.)
☐ YES	☐ NO	Body Piercing(s)
☐ YES	☐ NO	Any metal fragments
☐ YES	☐ NO	Aortic clip
☐ YES	☐ NO	Metal or wire mesh implants
☐ YES	☐ NO	Wire sutures or surgical staples
☐ YES	☐ NO	Metal rods in bones
☐ YES	☐ NO	Joint replacement _____
☐ YES	☐ NO	Bone/joint pin, screw, nail, wire, plate
☐ YES	☐ NO	Hearing aid (***Remove before MRI***)
☐ YES	☐ NO	Dentures (***Remove before MRI***)
☐ YES	☐ NO	Breathing disorder
☐ YES	☐ NO	Claustrophobia
☐ YES	☐ NO	Anxiety

Other, Please explain:_____

_____

Please mark on the figure below, the location of any implant or metal inside of, or on your body.



Before your MRI, please remove all metallic objects including keys, hairpins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material.

Note: YOU ARE REQUIRED TO WEAR EARPLUGS OR EARPHONES DURING THE MRI EXAMINATION

I have read the above and give consent to have a MRI exam. Date: _____/_____/_____

Signature: _____

Form completed by: ❑ Patient ❑ Relative _____

Name and Relationship to Patient

Reviewed by: (MRI Technologist) _____

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Do Not Place Below This Line.