NorthwestRadiologyNetwork
"Trusted Imaging Since 1967"

Name: _____
DOS: _____ **DOB:** _____
Height: _____ **Weight:** _____
BMI: _____

MR SCREENING FORM
Contrast: Y or N
_____cc's Prohance

Patient is to complete form, a technologist or family member may record informtion provided by patient. If patient is unable to provide information, the patient's emergency contact, next of kin or POA should provide information.

Information Provided By: **Patient** **Relative** **Caregiver** **Technologist** **Physician**

Due to the strong magnetic forces used in MRI, we need the following information to ensure your safety and produce a high quality exam.

Please check the appropriate box if you have any of the following

- ☐ Pacemaker/ICD
- ☐ Temperature Probes
- ☐ Mobilization sandbags
- ☐ Neurostimulators
- ☐ Middle Ear Prosthesis
- ☐ Swan Ganz Catheter or IABP
- ☐ Brain aneurysm clips, surgery clips, coils
- ☐ Recently swallowed GI Camera
- ☐ Cardiac Defibrillator

Please notify the MRI staff if any of the above items are checked, as this may prohibit the test from being performed.

- ☐ Aortic Clips
- ☐ Heart Valves
- ☐ Insulin Pump
- ☐ Medications/Drug Patch
- ☐ Electrodes
- ☐ Shrapnel of any kind
- ☐ IUD
- ☐ Tatoo(s) Location(s):_____
- ☐ Metal fragments in head,eye,skin
- ☐ Fractured bones treated with metal rods, metal plates, metal pins, metal screws, metal nails, or metal clips
- ☐ Hearing aids
- ☐ Shunts
- ☐ RF Surgical sponges
- ☐ Stent/Coil
- ☐ IVC filter
- ☐ Harrington Rod
- ☐ Prosthesis/Artificial Limb(s)
- ☐ Metal Mesh
- ☐ Wire Sutures

Other Devices (Please list): _____

Renal Assessment

History of Renal Disease	☐ Yes ☐ No	Single Kidney	☐ Yes ☐ No
History of Dialysis	☐ Yes ☐ No	History of Renal Cancer	☐ Yes ☐ No
History of Kidney Transplant	☐ Yes ☐ No	Hypertension with Medical Therapy	☐ Yes ☐ No
History of Kidney Surgery	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Are you claustrophobic	☐ Yes ☐ No		

Form Completed By: **Patient** **Relative** **Caregiver** **Technologist** **Physician**

I have answered the preceding questions to the best of my knowledge. All questions have been answered by my physician or MR staff. I hereby agree to have an MRI exam.

Signature of Person Providing Information: _____ **Date:** _____ **Time:** _____

Please remove all metallic objects; including keys, hair pins, barrettes, jewelry, watches, safety pins, paper clips, money clips, credit careds, coins, pens, Belts, metal buttons, pocket knives & clothing with metal in the material.

Technologist Use Only

If any implantable devices were checked, please indicate the following:

Manufacturer: _____ Name of Device: _____ Date Placed: _____

I have reviewed the above information with the patient; along with the importaance of not moving during the exam, the loud

Noise associated with the test, and the possibility of a rise in body temperature during the exam. I have instructed the patient
To use the squeeze ball if he/she needs anything at any time during the exam.

Technologist Signature: _____ Date: _____ Time: _____

Revised February 24, 2020