



# SAFETY SCREENING FORM FOR MAGNETIC RESONANCE PROCEDURES

Date \_\_\_\_\_ Name \_\_\_\_\_ Weight \_\_\_\_\_

Do you have any type of electronic, mechanical or magnetic implant?	Yes	No
Type _____		
Cardiac Pacemaker	Yes	No
Aneurysm clip	Yes	No
Nuerostimulators	Yes	No
Any type of internal electrodes or wires	Yes	No
Cochlear Implant or hearing aids	Yes	No
Any type of implanted pump	Yes	No
Any type of coil, filter or stent	Yes	No
Any dentures or other implants	Yes	No
Are they held in place by magnets	Yes	No

Have you ever had problems with an MRI in the past?	Yes	No
If yes please describe _____		
Have you ever had a surgical operation or procedure pertaining to this exam? If yes list all prior surgeries and approximate dates:	Yes	No
_____		
_____		

Have you ever gotten metal in your eyes or elsewhere in your body? If yes please describe.	Yes	No
_____		
Did you seek medical attention?	Yes	No
What treatment was needed? _____	Yes	No

Do you have a history of:					
Kidney disease	Yes	No	Liver Disease	Yes	No
Asthma	Yes	No	Liver Transplant	Yes	No
Allergic Respiratory disease	Yes	No		Yes	No
Do you have any drug allergies?	Yes	No		Yes	No
If yes please list _____					
_____					

Have you ever had contrast for an MRI?	Yes	No
Did you have any adverse reactions to the contrast?	Yes	No
If yes please describe _____		

Are you pregnant or suspect you may be pregnant?	Yes	No
Date of last menstrual period _____ Post-menopausal?		
_____		
Are you breast feeding?	Yes	No

Patient/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
Witness \_\_\_\_\_

				<b>Office Use Only</b>	
_____ cc with a _____ @ _____ in _____					
amt	ga & needle type	time	location		
Contrast _____	Lot _____	Exp Date _____			
Contrast Reaction Y N	Injection Complication Y N				
Inj. By _____	Radiologist Covering _____				

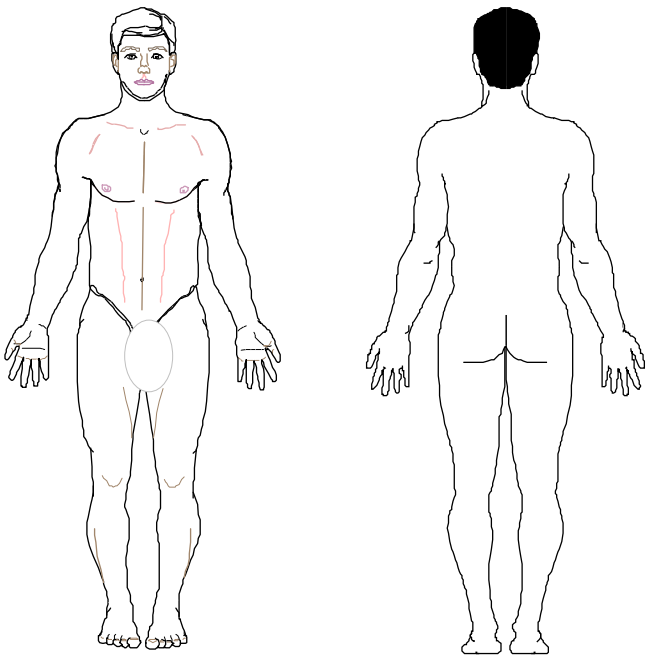


Patient Name:	Date:
Exam:	R      L
Reason for Exam:	
<b>Are you pregnant or suspect you are?</b>	
Previous Studies: Y N    Type: MR CT XR Other	

Where:	Available at time of scan Y N
Previous Report:	Available at time of scan Y N
Were the Studies Reviewed/Compared by:	
Tech Y N	Rad Y N

Are symptoms related to an injury? _____ Explain _____
Have you ever had surgery on the part being scanned today? _____
What are the symptoms of the region being scanned today: _____ _____ _____

Please indicate any special area(s) of pain or concerns on the diagram



Special Prescription Instructions/Requests:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tech Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_