

Date ___/___/___ Name _____
 Last Name First Name Middle Initial
 DOB ___/___/___ PT ID # _____ Age _____ Male Female Weight _____

Indication for exam? _____

YES NO
 _____ _____ **Cardiac pacemaker/defibrillator** _____
 _____ _____ **Aneurysm clip(s)** _____
 _____ _____ **Shunt** _____
 _____ _____ **Any type of coil, filter or stent** _____
 _____ _____ **Any implanted items** (e.g., pins, rods, screws, nails, plates, wires) _____
 _____ _____ **Prior injury from a metal object in your eye** (metal slivers, shavings, other metal objects)?
 If yes, did you seek medical attention? _____
 _____ _____ **Prior injury by a metal object/foreign body** (e.g., bullet, BB, shrapnel? If yes, please describe
 _____ _____
 _____ _____ **Kidney disease, asthma, or other allergic respiratory disease?**
 _____ _____ **Do you have acute or chronic renal failure?** Renal or Peritoneal? (please circle one)
 _____ _____ **Are you on Dialysis?**
 _____ _____ **Have you had an MRI in the past?** If yes, describe reason _____
 ** (Please bring prior films, if available, for comparison)
 _____ _____ Any surgical operation or procedure of any kind? If yes, list all prior surgeries and approximate
 dates: _____
 _____ _____ Have you ever had a contrast agent allergic reaction?
 _____ _____ Do you have any drug allergies? If yes, list drugs _____

THESE ITEMS MAY BE HARMFUL TO YOU DURING YOUR MRI SCAN OR MAY INTERFERE WITH THE SCAN
Answer YES or NO for every item. Do you have or have you had any of the following? If yes, describe on lines to right:

_____ _____ Any latex allergies
 _____ _____ Pulmonary Artery Catheter
 _____ _____ Any I.V. access port (e.g., Boviac, Port-a-Cath, Hickman, PICC line) _____
 _____ _____ Medication patch (e.g., Nitroglycerine, nicotine) _____
 _____ _____ Any type of electronic, mechanical, or magnetic implant _____
 _____ _____ Any type of internal electrode(s) or wire(s) _____
 _____ _____ Any type of surgical clip or staple _____
 _____ _____ Implanted drug pump (e.g., insulin, Baclofen, chemotherapy, pain medicine) _____
 _____ _____ Neurostimulator/Bio stimulator _____
 _____ _____ Spinal fixation device/Spinal fusion procedure _____
 _____ _____ Radiation seeds (e.g., cancer treatment) _____
 _____ _____ Artificial heart valve _____
 _____ _____ Artificial limb or joint/what and where _____
 _____ _____ Cochlear implant/Ear implant/Hearing aid _____
 _____ _____ Artificial eye/Eyelid spring/Eyelid weights _____
 _____ _____ Tissue expander (e.g., breast) _____
 _____ _____ Removable dentures, false teeth or partial plate _____
 _____ _____ Body piercing/location _____
 _____ _____ Wig, hair implants _____
 _____ _____ Tattoos or tattooed eyeliner _____

Female patient:
 _____ _____ Are you pregnant or could you be pregnant? Date of last menstrual period _____
 _____ _____ Are you breast feeding?
 _____ _____ Diaphragm, IUD, Pesary/type _____

Male patient
 _____ _____ Penile implant

I attest that this information is correct to the best of my knowledge. I have read and understand the contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Signature of Patient/Guardian/Relative/Spouse: _____ Date: _____

Procedure

- 1) All outpatients who are scheduled for an MRI examination, non-MRI personnel wishing to accompany the patient in the MRI exam room (e.g., parent), or volunteer must complete the CCF MRI Screening Form prior to undergoing the MRI study. Preliminary questions during the completion of the form can be answered by MRI administrative and/or nursing personnel.
- 2) All inpatients must complete a CCF MRI Screening Form before undergoing the MRI exam.
 - A. Alert inpatients should complete the form prior to leaving the nursing floor. The form will be distributed to the patient at the time the study is ordered. Parents/guardians should complete the form for pediatric patients. Nursing personnel will be responsible for sending the completed form with the patient to the MRI facility.
 - B. A responsible family member should complete the form for any patient who is unable to do so. If no such family member is available, it is the responsibility of the clinical service to complete the form to the best of their knowledge based on physical exam, history, and all available medical records. Any scars or deformities that may indicate prior surgery or foreign bodies must be investigated by x-rays or CT prior to the MRI exam. The clinical service must also document in the paper/digital chart that no family member is available, such screening was completed, that the MRI exam is vital for patient management, and that there are no alternative imaging exams that can provide comparable information with less risk (e.g., CT).
 - C. When MRI personnel contact the nursing floor to schedule the exam. They will receive a report from the RN. The presence of any implant or foreign body that is MRI unsafe will preclude the MRI exam and the patient will not leave the nursing floor.
 - D. Any MR-incompatible implants will be removed from the patient prior to leaving the floor if safe to do so. Any monitoring device/infusion pump will be exchanged in the MRI suite for comparable equipment that is qualified as MRI compatible and MRI safe prior to entering the exam room.
- 3) In the case of an implant in a patient, volunteer, or non-MRI personnel wishing to accompany a patient in the MRI exam room, written documentation of the specific type of implant must be available in the written/digital medical record or through a fax from the referring physician's office. Best efforts are then necessary to ensure MRI compatibility through documented testing of the implant prior to implantation, peer-reviewed documentation on MRI safety and compatibility, documentation carried by the patient (safety ID card), MRI safety testing of the make/model/type of object, or written documentation directly from the manufacturer or the manufacturer's web site.

