MRI OUTPATIENT SCREENING FORM

Patient: ______________________ DOB ___________ Acct Number: _________________ Weight _________ lb./kg stated/actual (circle)	Exam Requested ______________________________________ Appointment Date/Time ______________________________________	
Previous X-rays, CT, MRI Scans of Area to be Studied	**Date**	**Hospital**

yes	no	EVALUATION OF PATIENT EXCLUSIONS/SUITABILITY
		1. Do you have a pacemaker or defibrillator? 2. Is it MRI Conditional? Yes ___ No ___Device clinic:______________________________
		3. Do you have a stimulation device? (bladder, deep brain, gastric, hypoglossal, spinal cord, or vagus nerve Type: _______________________
		4. Do you have a medication pump or drug infusion device implanted in your body? Pain Clinic _____________________________
		5. Do you have a ventricular shunt?
		6. Do you have tissue expander? (breast)
		7. Have you had MRI contrast before?
		8. Allergic to contrast? Reaction: ____
		9. Are you claustrophobic? Do you have medication? Yes ___ No ___ Do you have a driver? Yes ___ No ___
		10. Have you ever done welding, grinding, been an auto mechanic? If so, did you wear eye protection? Yes ___ No ___
		11. Have you ever had anything metallic in or removed from your eyes?
		12. Have you ever had ear surgery? Facility and when: ____
		13. Do you have any otologic or other ear implants? (stapes, incus or cochlear)
		14. Have you ever had brain surgery? Facility and when: ____
		15. Do you have an aneurysm clip(s)? Facility and when: ____
		16. Do you have any metallic fragments or foreign bodies? (shrapnel BB or bullets)
		17. Are you diabetic?
		18. If so, do you have an insulin pump or continuous glucose monitor?
		19. Have you had any heart surgery? (stent, coil, valve or monitor) Facility and when: ____
		20. Do you have any coils, stents, or filters (umbrella for blood clots)? Facility and when: ____
		21. Do you have any internal electrodes or wires? Facility and when: ____
		22. Do you have any external pumps, monitors or devices?
		23. If male, do you have a penile prosthesis? Facility and when: ____
		24. If female, is there any chance you are pregnant? Date of LMP_____________________
		25. If female, do have an IUD, diaphragm or pessary?
		26. Have you ever had eye surgery? Facility and when: ____
		27. Do you wear hearing aids?
		28. Do you have any surgical clips, staples or sutures?

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		29. Do you have any artificial or prosthetic limbs or implants?
		30. Do you have any rods, pins, plates, screws, plates or wires in your body?
		31. Do you have a tattoo, tattoo eyeliner, or body piercing?
		32. Do you have any medication patches on your body? (nitroglycerin, pain, nicotine, or contraceptive)
		33. Do you have a history of kidney disease, renal impairment or on dialysis?
		34. If on dialysis what days of the week?
		35. Do you have a history of seizures?
		36. Are you able to lie flat on your back for 1 hour?
		37. Have you had blood work in the last 30 days? Facility and when: ____
		38. Do you have any open wounds being treated with silver nitrate?
		39. Have you swallowed a pill camera for endoscopy? Facility and when: ____
		40. Do you have anything implanted in your body not listed above?
List all previous surgeries		
Do you have asthma or any other respiratory disease?		
Drug allergies		

The answers to these questions are felt to be correct and have been answered to the best of my ability.

1st screening: Name of Person Answering Questions _______________________ Relation to Pt ____________

Secretary Review by ____ Date/Time ______________

2nd screening: Name of Person Answering Questions _______________________ Relation to Pt ____________

Secretary Review by ____ Date/Time ______________

Technologist Final Screening Review by __________________________________ Date/Time ______________