Name ______________________________

Birth date __ ____________How much do you weigh? ____________

Allergies: ______________________________

Reason for this exam: ______________________________

____

List any surgeries: ______________________________

____

SPRING HILL

IMAGING CENTER

MRI Patient Assessment and Screening Form

PATIENT LABEL

MRI Cannot be performed is "Yes" is answered to double asterisked (**) questions.
All "Yes" single asterisked (*) are to be referred to the radiologist.

DO YOU HAVE?

Yes [ ]	No [ ]	** Pacemaker, Defibrillator and/or Pacer Wires
Yes [ ]	No [ ]	** Aneurysm clip or brain surgery
Yes [ ]	No [ ]	* Neurostimulator (Tens Unit)
Yes [ ]	No [ ]	* Implanted electrodes, pumps, or electrical devices
Yes [ ]	No [ ]	* Shunt (spinal or intraventricular)
Yes [ ]	No [ ]	* Metallic foreign body (Gun shot wound or metal shavings in eyes)
Yes [ ]	No [ ]	* Prior ear eye or brain surgery
Yes [ ]	No [ ]	* Pregnant or nursing an infant
Yes [ ]	No [ ]	Prior vascular surgery
Yes [ ]	No [ ]	Joint or limb replacement
Yes [ ]	No [ ]	Metal rod, pin, screw or other
Yes [ ]	No [ ]	Orthopedic (bone) device
Yes [ ]	No [ ]	Prosthetic heart valve
Yes [ ]	No [ ]	Other heart surgery or stents
Yes [ ]	No [ ]	Any type prosthesis (eye, extremity, penile, etc.)
Yes [ ]	No [ ]	Hearing aid or Dentures
Yes [ ]	No [ ]	Permanent eyeliner, tattoos, body piercings
Yes [ ]	No [ ]	Transdermal/Skin/EKG or Medication Patches
Yes [ ]	No [ ]	Tissue Expander (i.e. breast, etc.)
Yes [ ]	No [ ]	Any previous MRI/CT scans

If yes, explain: ______________________

____

PLEASE ANSWER THE FOLLOWING:

Current or past history of Cancer? Yes [ ] No [ ]
If yes, please list: ______________________

____

Do you have Diabetes? Yes [ ] No [ ]

Do you have High Blood Pressure? Yes [ ] No [ ]

Do you have Kidney Disease? Yes [ ] No [ ]
(i.e. single kidney, dialysis, transplanted kidney, etc.)

Do you have Sickle Cell Anemia? Yes [ ] No [ ]

Do you have Liver Disease? Yes [ ] No [ ]

Date of Lab Results: ______________

Creatinine: ______________
Performed by I Stat? Yes [ ] No [ ]

GFR (calculated): ______________

You will be asked to remove all metallic objects before entering into the Magnet Room. This will include jewelry, keys, beepers, cell phones, watches, hair pins, wallet, coins, pocket knife, etc. A locker will be provided if you choose not to leave with a family member.

CONTRAST

Your physician or radiologist may deem it necessary for you to have an IV injection of a contrast liquid containing gadolinium to improve the quality of you MRI examination. Although gadolinium contrast agents have been used safely in millions of patients, minor reactions (principally headache or nausea) occur in 2% of patients, and serious or life threatening reactions have been reported in 1 in 400,00 patients. I have read and understand the above information, and have had my questions answered. I request that the MRI procedure be performed, including the injection of contrast if deemed necessary by my physician or the radiologist performing the MRI procedure.

X ______________________________ **Date:** ______________

Signature of Patient (Parent or Guardian)

History of previous reaction Yes [ ] No [ ] Asthma or Emphysema Yes [ ] No [ ] New IV Site by: ______________

If yes, explain ______________ [ ] Gadavist [ ] Magnevist [_____] ml's used MRI Technologist: ______________

______________ IV Access: _____ Gauge _____ Site [ ] Pre-existing

Current Medications: ______________________________

Tech Comments: ______________________________

Contrast Lot#: ______________ Exp Date: ______________

Saline Lot#: ______________ Exp Date: ______________

Updated Feb 2015