

## MRI OUTPATIENT SCREENING AND HISTORY FORM

Today's Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Sex: M F  
Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Ordering Physician: \_\_\_\_\_  
Reason for MRI and/or symptoms \_\_\_\_\_

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**Due to the magnetic field, each person entering the MRI suite must be thoroughly screened to ensure your safety during the procedure. Please inform us if you need help answering the following questions. Each question should be marked with YES or NO. DO NOT ENTER THE MRI ROOM IF YOU HAVE ANY QUESTIONS REGARDING ANY IMPLANT, DEVICE, OR OBJECT. THE MAGNET IS ALWAYS ON.**

YES NO

Cardiac Pacemaker/pacer wires

Implanted Defibrillator

Aneurysm Clips

Brain Surgery

If yes, date of surgery \_\_\_\_\_

Shunt (Spinal or Brain)

Biostimulator/Bone Stimulator

Neurostimulator

Tattoos, permanent make-up

or body piercings

Dentures or partial plates

History of welding/machinist work

Orbits cleared \_\_\_\_\_

YES NO

Cardiac Valve/Implant

Stents: cardiac, renal, or vascular

If yes, date of placement \_\_\_\_\_

Aortic Clips

Vena Cava Filters

Implantable Pumps: Insulin or medication

Metallic fragments or foreign bodies

Artificial Limbs/Joints

Any type of prostheses

(ear, eye, penile, etc.)

Hearing aids

Intestinal Capsule/Camera

Medication patches

**Please answer the following questions regarding YOUR medical history. If indicated, it may be necessary for you to have an IV contrast injection during your exam.**

YES NO

Are you pregnant or breastfeeding currently?

Do you have diabetes or high blood pressure?

Have you had surgery in the last six weeks

Have you ever had any history of cancer or multiple myeloma?

Do you have asthma, chronic lung disease, or breathing disorders?

Do you have congestive heart failure?

Do you have any blood or bleeding disorders?

Do you have any history of seizure or epilepsy?

Do you have renal disease, renal failure, or renal dialysis?

Have you had a liver transplant or history of end-stage liver failure?

Have you ever had any reaction to MRI contrast in the past?

Are you allergic to any medications? If yes, please list: \_\_\_\_\_

Please list your current medications: \_\_\_\_\_

\_\_\_\_\_

Over, please

**CONSENT FOR TREATMENT**

*I authorize Orthopaedic Specialists of Springfield, P.C., staff and physicians to provide routine care, and perform magnetic resonance imaging, diagnostic procedures, or x-ray treatments as may be necessary in the course of treatment. I have not been given a guarantee as to the results of this examination. I also authorize the release of information acquired in this exam to physicians and physician billing services, insurance companies (or their agents) for reimbursement purposes, and other institutions performing special testing or providing special equipment or transportation and/or to local state or federal agencies in accordance with applicable laws.*

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **! IMPORTANT INSTRUCTIONS**

Before entering the MRI environment or MR system room, you will be asked to remove ALL metallic objects including hearing aids, dentures, partial plates, keys, beepers, cell phones, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, lighter, pocket knife, nail clipper, metal shoe inserts, & clothing with metal fasteners or metallic thread in the fabric.

**PLEASE NOTE:** You will be asked to wear earplugs during the MR procedure to prevent any possible problems or hazards related to acoustic noise.

The above information is correct to the best of my knowledge. I have read and understand the content on this form and have had the opportunity to ask any questions regarding the MRI procedure that I am to undergo.

Patient/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Information reviewed by \_\_\_\_\_

*MRI Staff member signature*

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#### **For clinical use only: IV injection of contrast**

\_\_\_\_\_ cc of \_\_\_\_\_ Lot# \_\_\_\_\_ Exp \_\_\_\_\_

*Contrast name*

In \_\_\_\_\_ @ \_\_\_\_\_ am/pm \_\_\_\_\_ by \_\_\_\_\_  
*site location Time # of attempts Signature*

Complications: *NO YES* Explain \_\_\_\_\_

Serum Creatinine: \_\_\_\_\_ Date: \_\_\_\_\_ eGFR \_\_\_\_\_ ml/min/1.73m<sup>2</sup>