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Magnetic Resonance Imaging Patient Screening Form

Magnetic resonance (MR) facilities and units can refer to this sample MR screening form as a guide in developing a comprehensive MR screening form. All questions on the screening form should be answered completely to avoid confusion or misunderstanding as to the metal medical history and metal exposure history of the patient. The completed screening form should be reviewed with the patient (or patient's representative) by two separate MR personnel to verify completeness and accuracy.

Patient Identification No.: ______________________________

Patient Name: ____________________ Age: ______ Date of Birth: __________ Today's Date: __________

Home Address: ______________________________

Gender: __________ Height: __________ Weight: __________

Area of Body to Be Examined: ____________________

Reason for MRI: ____________________

Referring Physician: ____________________ Telephone No.: ____________________

1. Have you ever had a prior surgical procedure of any kind? ❑ Yes ❑ No

If yes, please indicate the date (approximate if unknown) and type of surgery:

Date __________ Type of Surgery ____________________

Date __________ Type of Surgery ____________________

Date __________ Type of Surgery ____________________

2. Have you ever had a prior diagnostic imaging study or examination (e.g., MRI, CT, X-ray)? ❑ Yes ❑ No

If yes, please list:	Body Part	Date	Facility
MRI			
CT/CAT Scan			
X-ray			
Ultrasound			
Nuclear Medicine			
Other __________			

3. Have you ever experienced any problem related to a previous MR procedure? ❑ Yes ❑ No

If yes, please explain : ______________________________

4. Have you ever been a welder, grinder, or sheet metal worker? ❑ Yes ❑ No

If yes, please explain : ______________________________

5. Have you had an eye injury involving a metallic object or fragment (e.g., metallic slivers, shavings)? ❑ Yes ❑ No

If yes, please explain : ______________________________

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6. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel)? ❑ Yes ❑ No
If yes, please explain : ______________________________

7. Have you recently had a small bowel endoscopy study with ingestion of a small camera capsule? ❑ Yes ❑ No
If yes, how recent: ______________________________

8. Are you currently taking or have you recently taken any medication or drug? ❑ Yes ❑ No
If yes, please list medications or drugs: ______________________________

9. Are you allergic to any medication or drug? ❑ Yes ❑ No
If yes, please list medications or drugs: ______________________________

10. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, or seizures? ❑ Yes ❑ No
If yes, please explain: ______________________________

11. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to contrast medium or dye used for MRI, CT, or x-ray procedures? ❑ Yes ❑ No
If yes, please explain: ______________________________

12. Have you ever had a reaction to or have been told that you should not have contrast medium injections for imaging studies? ❑ Yes ❑ No
If yes, please explain: ______________________________

For Female Patients:

13. Date of last menstrual period: ______________ **Are you postmenopausal?** ❑ Yes ❑ No

14. Are you or could you be pregnant or experiencing a late menstrual period? ❑ Yes ❑ No

15. Are you taking oral contraceptives or receiving hormonal treatment? ❑ Yes ❑ No

16. Are you taking any type of fertility medication or having fertility treatments? ❑ Yes ❑ No
If yes, please explain: ______________________________

17. Are you currently breastfeeding? ❑ Yes ❑ No

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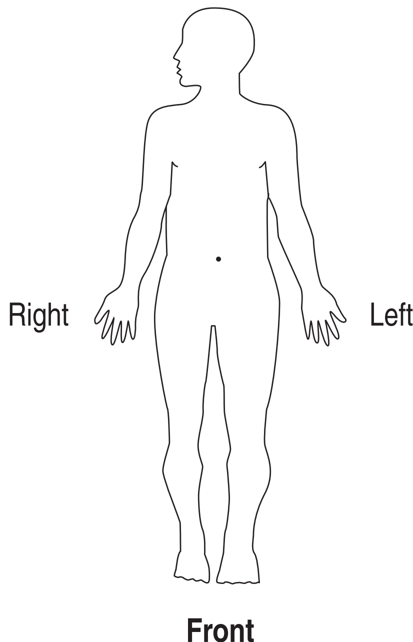
CAUTION	Magnetic resonance imaging (MRI) systems use strong magnetic fields and radio-frequency energy for imaging soft tissue in the body. Certain implants, devices, or objects may pose a hazard to individuals in close proximity to the magnet of the MRI system and/or may interfere with the MRI procedure.

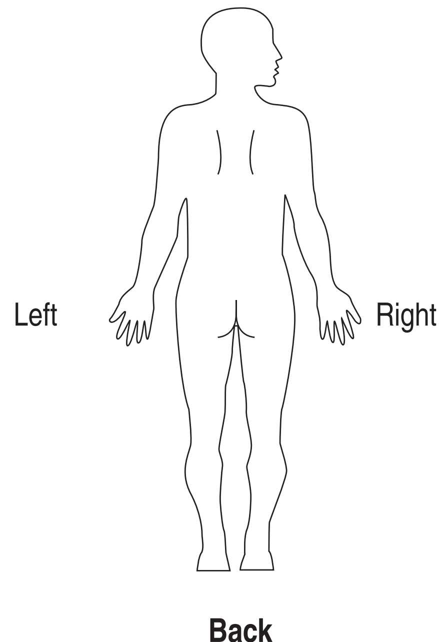
Please indicate if you currently have or ever had any of the following:

Item	Yes	No
Aneurysm clip(s)	❑ Yes	❑ No
Cardiac pacemaker	❑ Yes	❑ No
Implanted cardioverter defibrillator (ICD)	❑ Yes	❑ No
Electronic implant or device	❑ Yes	❑ No
Magnetically activated implant or device	❑ Yes	❑ No
Neurostimulator	❑ Yes	❑ No
Spinal cord stimulator	❑ Yes	❑ No
Bone growth/bone fusion stimulator	❑ Yes	❑ No
Internal electrodes or wires	❑ Yes	❑ No
Cochlear, otologic, or other ear implant (including hearing aid)	❑ Yes	❑ No
Insulin or other infusion pump	❑ Yes	❑ No
Implanted drug infusion device	❑ Yes	❑ No
Any type of prosthesis (e.g., eye, penile)	❑ Yes	❑ No
Heart valve prosthesis	❑ Yes	❑ No
Blood clot filter	❑ Yes	❑ No
Eyelid spring or wire	❑ Yes	❑ No
Artificial or prosthetic limb	❑ Yes	❑ No
Metallic stent, filter, or coil	❑ Yes	❑ No
Shunt (spinal or intraventricular)	❑ Yes	❑ No
Vascular access port and/or catheter (e.g., Broviac, Port-A-Cath, Hickman)	❑ Yes	❑ No
Radiation seeds or implants	❑ Yes	❑ No
Swan-Ganz or thermodilution catheter	❑ Yes	❑ No
Medical patch (transdermal) (e.g., Nicotine, Nitroglycerine)	❑ Yes	❑ No
Any metallic fragment or foreign body	❑ Yes	❑ No
Wire mesh implant	❑ Yes	❑ No
Tissue expander (e.g., breast)	❑ Yes	❑ No
Surgical staples, clips, or metallic sutures	❑ Yes	❑ No
Joint replacement (hip, knee, etc.)	❑ Yes	❑ No
Bone/joint pin, screw, nail, wire, plate, etc.	❑ Yes	❑ No
Intrauterine device (IUD), diaphragm, or pessary	❑ Yes	❑ No
Braces, dentures, or partial plates	❑ Yes	❑ No
Tattoo or permanent makeup	❑ Yes	❑ No
Body piercing jewelry	❑ Yes	❑ No
Wig or hair implants	❑ Yes	❑ No
Hair accessories (e.g., hairpins)	❑ Yes	❑ No
Other implant	❑ Yes	❑ No
Breathing problem or motion disorder	❑ Yes	❑ No
Claustrophobia	❑ Yes	❑ No

Please mark on the figure(s) below the location of any implants, metal, tattoos, or permanent makeup inside or on your body.



Front



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Patient Instructions

Please use the hospital-supplied hearing protection (e.g., earplugs, headphones) during the MRI scan because the MRI scanner produces significant acoustic noise that may affect your hearing or that you may find uncomfortable.

Please remove all metallic objects before entering the MRI scan room, including the following:

Jewelry (e.g., earrings, rings, body piercings), hairpins, hair clips, dentures, false teeth, partial dental plates, hearing aids, eyeglasses, watch, pager, cell phone, keys, safety pins, paper clips, money clip, any magnetic strip cards (e.g., bank, credit), coins, pens, pocketknife, nail clipper, tools, and clothing with metal fasteners or containing metal thread.

It may be necessary for you to remain still for up to one hour while lying on your back during the MRI procedure. If you do not believe you can remain still for that long, please discuss this with the MRI technologist or radiologist before entering the MRI scan room.

Discuss any questions or concerns that you may have or if you are unsure if an item should be removed with the MRI technologist or radiologist prior to entering the MRI scan room.

I have reviewed the above information and attest that the information is accurate to the best of my knowledge. I have read and understand the entire contents of this form and had the opportunity to ask questions regarding this information and the MRI procedure.

Patient Name (please print): ____________________

Patient Signature: ____________________ Date:__________

Patient Guardian or Authorized Representative Name (please print):____________________

Patient Guardian or Authorized Representative Signature:____________________ Date:__________

Relationship to Patient: ____________________

Form Information Reviewed by: Date:__________

❑ MRI Technologist ❑ Registered Nurse ❑ Radiologist ❑ Other:____________________

For more information, go to http://www.patientsafetyauthority.org.
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Adapted with permission from:

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References

Appendix 3: safety screening form, MR hazard checklist, and patient instructions. In: Kanal E, Barkovich A, Bell C, et al. ACR guidance document for safe MR practices: 2007. *Am J Roentgenol* 2007 Jun;188(6):1447-74.

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MRI safety checklist and patient consent form [online]. 2005 Jan [cited 2009 Feb 23]. Available from Internet: http://www.nwdcdi.com/documents/mriconsent.pdf.

MRI safety screening [form online]. [cited 2009 Feb 23.] Available from Internet: http://www.umich.edu/~fmri/safety_screening.pdf.

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