

COMMUNITY MEDICAL CENTER
MRI Breast Screening Questionnaire

MRI Telephone #: 732-557-2590

MRI Fax #: 732-557-2423

Patient Name:	Ordering Physician:
Patient's Telephone #:	Insurance Carrier:
Height: Weight:	Group ID #:
DOB: Age:	Pre-Certification #:
Test Ordered:	Scan Date:

Attach a list of **ALL** medications you are currently taking

The following items may interfere with MR imaging. Do you have any of the following?

Y/N Cardiac Pacemaker/Defibrillator	Y/N Harrington rods for scoliosis
Y/N Heart Valve	Y/N Neurostimulator (Tens unit)
Y/N Internal Pacing Wires	Y/N Electrodes (on body, head or brain)
Y/N Aneurysm Clips	Y/N Biomedical implants/stimulators
Y/N History of Renal Disease	Y/N IUD
Y/N Are you a diabetic?	Y/N Pregnant Date of LMP: _____
	Breast Feeding: Y / N
Y/N Vascular Stents, Filters, Coils	Y/N Tattoo/Permanent eyeliner
Y/N Brain Clips	Y/N Body piercing(s)
Y/N Cochlea Implant in ear	Y/N Insulin pump
Y/N Metal fragments removed from eyes	Y/N Shunt (spinal or ventricular)
Y/N Metal mesh implants (body/head)	Y/N Transdermal patch
Y/N Shrapnel, buckshot or bullets	Y/N Claustrophobia*
Y/N Metal plates, screws, pins, staples	Y/N Swallowing disorder
Y/N Prosthesis, eye, orbital, penile implant	Y/N Breathing disorder
Y/N Joint replacement	Y/N Can you lie flat for 30 minutes or more
Y/N Fractured bones treated with rods/pins	Y/N Allergic to contrast media
Y/N Any Surgery	Y/N Are you presently working or have you worked as a machinist, metal worker, or in any profession or hobby grinding metal**

PLEASE NOTE:

- * **If patient is claustrophobic, Please OBTAIN SEDATION ORDER from Physician.**
- ** **If patient answered yes to having worked in a profession or hobby that either presently or previously involved grinding metal, ORBITS must be ordered and cleared by Radiologist.**

Patient Signature: _____ **Date:** _____

Screened By: _____ **Date:** _____
 (RN Signature)

Screened By: _____ **Date:** _____
 (MR Technologist Signature)