

**COMMUNITY MEDICAL CENTER
MRI Screening Questionnaire**

MRI Fax # 12141

| | |
|---------------|--|
| Patient Name: | Room #: |
| Med. Rec. #: | Height: Weight: |
| Physician: | DOB: Age: |
| Test Ordered: | Scan Date: |

**OUTPATIENTS: 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.

INPATIENTS: MUST REMOVE DENTURES, JEWELRY, PUMPS, AND ELECTRODES BEFORE COMING TO MRI.

Patient Signature (Outpatient Only): _____ *Date:* _____

| | |
|------------------------------------|--------------------|
| <i>Screened By:</i> _____ | <i>Date:</i> _____ |
| <i>(RN Signature)</i> | |
| <i>Screened By:</i> _____ | <i>Date:</i> _____ |
| <i>(MR Technologist Signature)</i> | |