

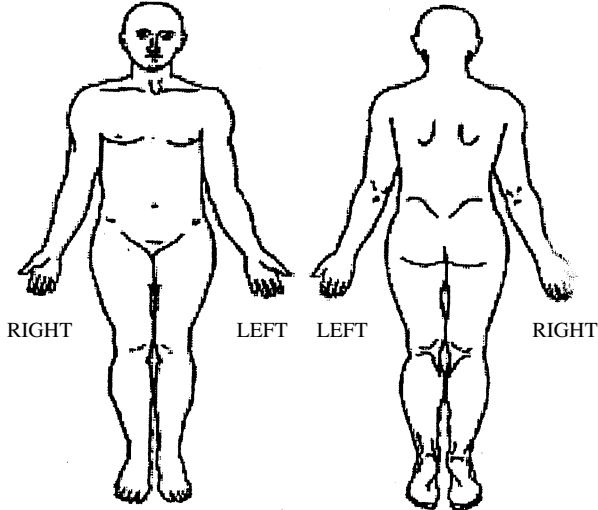


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy.) **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. **The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

- 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 Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No Insulin or infusion pump
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Heart valve prosthesis
- 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
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or thermodilution catheter
- Yes No Medication patch (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 IUD, diaphragm, or pessary
- Yes No Dentures or partial plates
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No hearing Aid
(Remove before entering the MR system room)
- Yes No Other implant _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must 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, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____/____/____
Signature

Form Completed By: Patient Relative Other _____
Print Name Relationship to patient

Form Information Reviewed By: _____
Print Name Signature

MRI Technologist Radiologist Other _____



Patient Label

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS



HNMRD

Ethnicity: Caucasian Africian/American Hispanic Other _____

Height _____ Weight _____

Male Female Body Part to be Examined _____

Please describe in brief your injury or symptoms _____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? Yes No

If yes, please indicate date and type of surgery: _____

Date ____ / ____ / ____ Type of surgery _____

Date ____ / ____ / ____ Type of surgery _____

2. Cardiac Pacemaker? _____ Yes No

3. Have you experienced any problem to a previous MRI examination or MR procedure? Yes No

If yes, Please describe: _____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? Yes No

If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? Yes No

If yes, please describe: _____

6. Are you currently taking or have you recently taken any medication or drug? Yes No

If yes, please describe: _____

7. Are you allergic to any medication? Yes No

If yes, please list: _____

8. Do you have a history of asthma allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? Yes No

9. Do you have anemia or any disease(s) that affects your blood? Yes No

If yes, please describe: _____

10. Do you have a history of seizures? Yes No

If yes, please describe: _____

11. Do you have a history of renal (kidney disease), liver disease, or diabetes? Yes No

If yes, please describe: _____

12. Are you on dialysis? _____ Yes No

13. Do you have a history of cancer? If yes, what type _____ Yes No

For female patients:

14. Date of last menstrual period? ____ / ____ / ____ Post menopausal? _____ Yes No

15. Are you pregnant or experiencing a late menstrual period? _____ Yes No

16. Are you taking oral contraceptives or receiving hormonal treatment? _____ Yes No

17. Are you taking any type of fertility medication or having fertility treatments? Yes No

If yes, please describe: _____

18. Are you currently breastfeeding? _____ Yes No



Patient Label