NORTH CENTRAL SURGICAL CENTER

Magnetic Resonance Imaging
SCREENING FORM FOR PATIENTS

The information requested on this form is *very important.* Please answer *all* questions as thoroughly as possible. *The patient or patient's legally authorized representative is responsible for the accuracy of the requested information.*
Do you have any of the items or conditions listed below? Please check YES or NO for each item or condition. You will see the words LOCATION or DATE next to some items. If you see the word LOCATION next to an item that you have, please write in where the item is located on/in your body. If you see the word DATE next to an item that you have, please write in the approximate date that you received the item.

YES	NO	Patient Weight:	YES	NO	
		ANY metal inside your body anywhere?			Tissue Expander Date:
		Cardiac pacemaker			Penile implant
		Implanted defibrillator			Thermodilution Swan-Ganz catheter
		Aneurysm clips Location:			Ph Graph Probe
		Carotid artery clips Date:			Neurostimulation system
		Stent, coil or filter (please circle) Location: Date:			Intrauterine Device (IUD) Brand/Type:
		Surgical staples, clips or metallic sutures			Bone growth/bone fusion stimulator
		Magnetically activated implant or device			Implanted drug infusion pump
		Internal electrodes or wires			Allergic reactions to Intravenous contrast
		Artificial heart valve Date:			Claustrophobia (nervous in small places)
		Hearing aid			Kidney problems now or in the past
		Spinal or ventricular shunt			Breastfeeding
		Fractured bones or spine treated with:			Medication pump
		Metal rod			Ingested camera pill
		Metal plates			Metal fragments (shrapnel or gunshot wound)
		Metal pins			Location/Date:
		Screws			Prosthesis of any kind? Type:
		Tattoos or permanent makeup Location(s):			Middle ear/cochlear implant LEFT RIGHT BOTH
		Body Piercing Location(s):			Other implants: Location/Date
		Medication patch			
		Silver impregnated wound dressing			Metal in eyes LEFT RIGHT BOTH

No one should enter the MRI scan room with: * watch * metal zippers * firearms * removable dental work * pens * hearing aid * keys * coins * * pocket knife * hairpins * belt buckle * bra * purse/wallet/money clip/credit cards * cell phones or other electronic or metallic devices *

Signature of person completing the form_____

Form completed by ☐ Patient ☐ Relative ☐ Caregiver ☐ Other_____

THIS SECTION TO BE COMPLETED BY MRI STAFF

Signatures of person(s) reviewing the MRI Screening Form for Patients:
1)_____2)_____

Were x-rays obtained? ☐ Yes ☐ No Date_____ Time_____ Films cleared by _____MD

Contrast Type_____ Amount _____ml Lot #_____ Exp. Date_____Needle Size_____

Physician covering contrast:_____ IV started by: _____

Power Injector Used? ☐ Yes ☐ No Rate_____ ml per _____ seconds