PHYSICIANS' CLINIC of Iowa, P.C.
IMAGING

MRI SCREENING AND SAFETY FORM

Fill out this form completely. MRI uses a very strong magnet. Metal objects in your body may be hazardous. Metal objects on your body or clothing may be hazardous to you and others in the MRI scan room. You must remove all loose or removable objects containing metal before entering the MRI scan room.

Patient Name: _____ Patient DOB: _____

What problem or symptoms is this test evaluating: _____

Please indicate if you have any of the following:

Yes No

- ☐ ☐ Cardiac pacemaker or defibrillator
- ☐ ☐ Internal or external electrodes or wires
- ☐ ☐ Brain aneurysm clip(s) or coils
- ☐ ☐ Currently wearing a Neulasta® Device?
- ☐ ☐ Heart valve prosthesis
- ☐ ☐ Wires from a pacemaker or defibrillator
- ☐ ☐ Implantable loop recorder/insertible cardiac monitor
- ☐ ☐ Metallic stent, filter, coil, etc.
- ☐ ☐ Neurostimulator, TENS unit, or spinal stimulator
- ☐ ☐ Electrical Bone Growth Stimulator for spinal fusion
- ☐ ☐ Pump for Insulin or other medication (Minimed, Mini Link)
- ☐ ☐ Medication patch (fentanyl, nicotine, nitroglycerine, etc.)
- ☐ ☐ Cochlear implant or other ear implant
- ☐ ☐ Hearing aid (remove before entering MRI room)
- ☐ ☐ Shunt (spinal or intraventricular)
- ☐ ☐ Post-surgical epidural catheter for pain control
- ☐ ☐ Vascular access port or catheter
- ☐ ☐ Temperature Sensing Foley Catheter
- ☐ ☐ Swan-Ganz or thermodilution catheter
- ☐ ☐ Artificial or prosthetic limb
- ☐ ☐ Joint replacement (hip, knee, etc.)
- ☐ ☐ Orthopedic brace, splint or device
- ☐ ☐ Bone pin, screw, nail, wire, plate, etc.
- ☐ ☐ Any type of prosthesis (eye, penile, etc.)
- ☐ ☐ Surgical staples, clips or metal sutures
- ☐ ☐ Radiation seeds or implants
- ☐ ☐ Wire mesh implant
- ☐ ☐ Tissue expander
- ☐ ☐ IUD, diaphragm or pessary
- ☐ ☐ Dentures or partial plates
- ☐ ☐ Tattoo or permanent makeup
- ☐ ☐ Body piercing jewelry
- ☐ ☐ Wound dressing containing silver
- ☐ ☐ Have you had a capsule (pill) endoscopy study in the last 30 days?
- ☐ ☐ Have you had clips placed during an endoscopy procedure?
- ☐ ☐ Have you ever been injured by a metallic object (bullet, BB, shrapnel, buckshot, etc.)?
- ☐ ☐ Magnetically-activated implant or device
- ☐ ☐ Have you ever had an eye injury involving a metallic object or fragment **FOR WHICH YOU SOUGHT MEDICAL TREATMENT?** (metallic sliver, etc…)
- ☐ ☐ Eye or eyelid implant or metal or cosmetic contact lenses
- ☐ ☐ Cataract surgery prior to 1995
- ☐ ☐ Any other metal in your body, list: _____
- ☐ ☐ Any other surgical implant, list: _____

If you have a medical card with surgical implant name/model, please show this to the MRI technologist

I have been instructed to remove all metal that I may have on my body, clothing and pockets before entering the scanning room.

_____
Initialed by Patient

OVER →

Physicians' Clinic of Iowa

MRI SCREENING AND SAFETY FORM

PLEASE COMPLETE

Yes No

- ☐ ☐ Are you claustrophobic?
- ☐ ☐ Have had any problem related to a previous MRI procedure?_____
- ☐ ☐ Have you taken any sedation medication for this exam?_____
- ☐ ☐ Do you have a history of asthma or respiratory disease?
- ☐ ☐ Have you ever had a reaction to contrast (dye) used for an MRI, CT, cath procedure or X-ray exam? If yes, explain: _____
- ☐ ☐ Contrast injection for MRI or CT scan, cath procedure or x-ray test in last 30 days? (If Yes, may need creatinine/eGFR - technologist will consult radiologist)
- ☐ ☐ Contrast injection for MRI or CT scan, cath procedure or x-ray test in last 48 hours? (If Yes, may need creatinine/eGFR 24 hours after the prior test - technologist will consult radiologist)
- ☐ ☐ Contrast injection for MRI scan in last 6 months? (If Yes, technologist will consult radiologist)

Your current weight:_____ height:_____

<u>eGFR screening indications</u> (need creatinine/eGFR if Yes to any of the following, or if age 60 yrs or older):

Yes No

- ☐ ☐ Kidney disease, impaired kidney function, partial or complete kidney removal?
- ☐ ☐ High blood pressure or history of heart disease?
- ☐ ☐ Diabetes?
- ☐ ☐ Do you have a history of liver transplant, severe liver disease or liver failure? (if so, please circle)
- ☐ ☐ Do you receive dialysis? ☐ Hemodialysis ☐ Peritoneal dialysis
  If so, when is your next dialysis scheduled?_____

<u>Female patients</u>:

Yes No

- ☐ ☐ Are you receiving fertility medication or treatment?
- ☐ ☐ On oral contraceptives or hormonal treatment?
- ☐ ☐ Experiencing a late period?
- ☐ ☐ Are you postmenopausal (last period more than 12 months ago)?

Yes No

- ☐ ☐ Are you pregnant?
- ☐ ☐ Are you breastfeeding?

Date of last menstrual period:_____

****DO NOT ENTER MRI SCAN ROOM IF YOU HAVE ANY UNANSWERED QUESTIONS OR CONCERNS****

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form, have had an opportunity to ask questions about the information on this form and the MRI procedure I am about to undergo, and have had all of my questions answered.

<u>Signature of patient</u> (or other responsible adult):_____Date:_____

Form completed by: ☐ Patient ☐ Other:_____
Print name (and title or relationship to patient)

Form Reviewed by Technologist:_____