



MRI SCREENING

MRI PATIENT SCREENING

DOB: ()
CSN:
DOS:
MRN: EMRN:

Patient Identification Information

List all Surgeries: _____ No Known Surgeries

Patient Status: Capacitated Incapacitated Minor
If no: name of informant: _____
If no: Informants phone number _____
Is the Patient Pregnant? YES NO

What is the patients height? _____
What is the patients weight? _____
Does patient have a Gadolinium Allergy? YES NO
If yes, is patient pre-medicated? YES NO

- Internal Defibrillator/Pacemaker YES NO
Implanted pump/stimulator/abandon wires YES NO
Continuous Glucose Monitor, Insulin pump, Diabetic Sensor YES NO
Tissue Expander YES NO
Blood Vessel Coil/Stent/Heart Valve/IVC Filter YES NO
Aneurysm Clip YES NO
Programmable Shunt YES NO
Cochlear Implant/Ear Implant/Hearing aide YES NO
Eye Implants/Eyelid Weights YES NO
History of Welding/Metal fragments in the eyes YES NO
Metal Tracheostomy YES NO
Harrington/MAGEC Rods YES NO
Penile Prosthesis YES NO
IUD YES NO
Body Piercings/Tattoos YES NO

- Medication/Nicotine Patch YES NO
Endoscopy/Colonoscopy with capsule pill or clip placement in the last 8 weeks YES NO
Any implants or foreign objects (ex. Bullets, BBs, Shrapnel, metal object, artificial limb) YES NO
If Yes, List Here: _____
Any objects in or on the body not covered above YES NO
If Yes, List Here: _____
Claustrophobia or fear of tight places YES NO
Receiving Contrast YES NO
Select all that apply: None
 Allergy to Gadolinium AKI
 CKD Diabetes
 Dialysis Kidney Ablation
 Kidney Transplant Partial Kidney Removal
 Sickle Cell Single Kidney Removal

Part A Patient or Guardian
I attest that the above information is correct. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form, for the MRI procedure that is about to be performed.
Signature of Patient Guardian: _____ Date: _____ Time: _____

Part B Provider
If patient is not alert and oriented the provider must complete and sign
I attest that the above information has been confirmed and is verified by: Patient's Family/Guardian Other
Signature of Provider completing this form: _____ Provider ID number: _____ Date: _____
Print Provider's Name: _____ Provider's Contact number: _____

Part C Radiologist
I attest and verify that there is NO metal in the imaged body part. Radiologist's Signature/ID number: _____ Date/Time: _____

THIS SPACE IS FOR DEPARTMENT USE ONLY
Patient Wanded Prior to entering Zone4 YES NO
Pt given ear plugs / headset YES NO
Initial Reviewed By: _____ Date: _____ Time: _____
Final Reviewed By: _____ Date: _____ Time: _____