The Johns Hopkins Hospital

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: _____
Signature

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: _____
Signature
Time: _____

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 **Orbits:** ☐ YES ☐ NO

Patient Wanded Prior to entering Zone4 ☐ YES ☐ NO **Pt given ear plugs / headset** ☐ YES ☐ NO

Initial Reviewed By: _____ _____ Date: _____ Time: _____
Print Name Signature

Final Reviewed By: _____ _____ Date: _____ Time: _____
Print Name Signature