

PATIENT AMBULATORY
YES/NO

PATIENT ON O2:
YES/NO

WEST WICHITA FAMILY PHYSICIANS, P.A.
MRI PROCEDURE SCREENING FORM

PRE-CERT _____
CLAUSTROPHOBIC: YES/ NO
IF YES, SCRIPT GIVEN:
YES/ NO

Date _____ Patient Chart # _____ Physician _____
Patient Name _____ Birth date _____ Age _____
Phone: Hm. _____/Wk. _____ Sex _____ Height _____ Weight _____
Procedure: _____
Diagnosis: _____
Clinical History: _____

IF PATIENT IS > 60 YEARS OR DIABETIC THEY MUST HAVE A CREATININE LEVEL WITHIN 6 WEEKS **Date:** _____ **Creatinine:** _____ **GFR:** _____ **(MRI to calculate)**

	YES	NO
Have you ever had a surgical procedure or operation of any kind?.....	_____	_____
If yes, please list all prior surgeries and approximate dates: _____		

Have you ever been diagnosed with cancer?.....	_____	_____
If yes, list date, type, area of body, and how it was treated (surgery, chemo, etc):		

Have you ever been injured by a metallic foreign body (bullet, BB, shrapnel, etc)?	_____	_____
Please describe: _____		

Have you ever had an injury to the eye involving a metallic object (metallic slivers, shavings, foreign body, etc)?.....	_____	_____
Please describe: _____		

Was the metal in the eye removed by a physician?.....	_____	_____
Do you have a history of seizure, asthma, or allergic respiratory disease?.....	_____	_____
Are you on renal dialysis or have a history of renal disease? NEED 6 wk Creat.	_____	_____
Are you diabetic?.....	_____	_____
Have you had liver surgery or have severe liver disease? NEED same day Creat.	_____	_____
Have had a liver transplant or pending a liver transplant? NEED same day Creat.	_____	_____
Have you ever had a reaction to a contrast medium used for MRI or CT?.....	_____	_____
Which one? MRI _____ CT _____ Describe reaction: _____		

Are you pregnant or do you suspect that you are pregnant?.....	_____	_____
Are you breast feeding?.....	_____	_____
Last menstrual period: _____ Post-menopausal?.....	_____	_____

PERTINENT PREVIOUS STUDIES RELATED TO THIS EXAM:	LOCATION	DATE
X-rays	_____	_____
Computed Tomography	_____	_____
Ultrasound	_____	_____
Nuclear Medicine	_____	_____
MRI	_____	_____

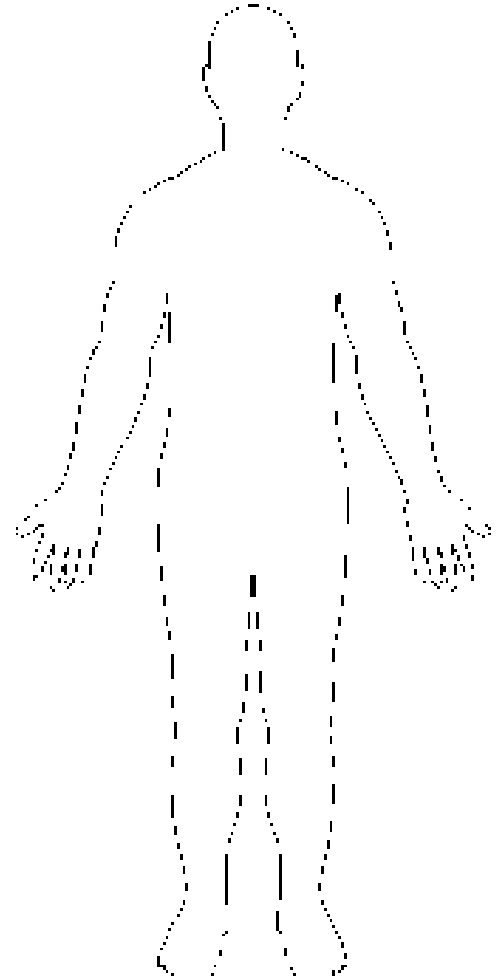
Earplugs are available for your MRI examination since some patients may find the noise levels unacceptable.

THE FOLLOWING ITEMS MAY BE HAZARDOUS OR MAY INTERFERE WITH THE MRI EXAMINATION BY PRODUCING AN ARTIFACT.

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

- | YES | NO | |
|-----|-----|--|
| ___ | ___ | Cardiac Pacemaker |
| ___ | ___ | Aneurysm Clip(s) |
| ___ | ___ | Implanted Cardiac Defibrillator |
| ___ | ___ | Neurostimulator |
| ___ | ___ | Any Type of Biostimulator Type: _____ |
| ___ | ___ | Any Type of Internal Electrode(s), including: |
| ___ | ___ | Pacing wires |
| ___ | ___ | Cochlear Implant |
| ___ | ___ | Other: _____ |
| ___ | ___ | Implanted Insulin Pump |
| ___ | ___ | Swan-Ganz Catheter |
| ___ | ___ | Halo Vest or Metallic Cervical Fixation Device |
| ___ | ___ | Any Type of Electronic, Mechanical, or Magnetic Implant Type: _____ |
| ___ | ___ | Hearing Aid |
| ___ | ___ | Any Type of Intravascular Coil, Filter, or Stent (Gianturco coil, Gunther IVC filter, Palmaz stent, etc) |
| ___ | ___ | Implanted Drug Infusion Device |
| ___ | ___ | Any Type of Foreign Body, Shrapnel, or Bullet |
| ___ | ___ | Heart Valve Prosthesis |
| ___ | ___ | Any Type of Ear Implant |
| ___ | ___ | Penile Prosthesis |
| ___ | ___ | Orbital/Eye Prosthesis |
| ___ | ___ | Any Type of Implant held in place by a Magnet |
| ___ | ___ | Any Type of Surgical Clip or Staple(s) |
| ___ | ___ | Vascular Access Port |
| ___ | ___ | Intraventricular Shunt |
| ___ | ___ | Artificial Limb or Joint |
| ___ | ___ | Dentures |
| ___ | ___ | Diaphragm |
| ___ | ___ | IUD |
| ___ | ___ | Wire Mesh |
| ___ | ___ | Transdermal Skin Patch |
| ___ | ___ | Any Implanted Orthopedic Item(s) (Pins, Screws, Clips, Plates, etc) Type: _____ |
| ___ | ___ | Any Other Implanted Item, Type: _____ |
| ___ | ___ | Tattooed Eyeliner |
| ___ | ___ | Body Piercing-If yes, where? _____ |
| ___ | ___ | (All body piercings must be removed prior to exam) |
| ___ | ___ | Hair Extensions |

PLEASE MARK ON THIS DRAWING THE LOCATION OF ANY METAL INSIDE YOUR BODY.



MRI utilizes a strong magnetic field. All metallic personal belongings (watches, jewelry, pagers, cellular phones, etc) must be removed as well as clothing items that have metallic buttons, fasteners, or zippers. Please dress accordingly (sweats, shorts, etc) or bring a change of clothes. We strongly recommend that you leave metallic personal belongings at home or locked in your vehicle.

Patients signature _____

MD/RN/RT name _____

MD/RN/RT signature _____