PATIENT AMBULATORY 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.

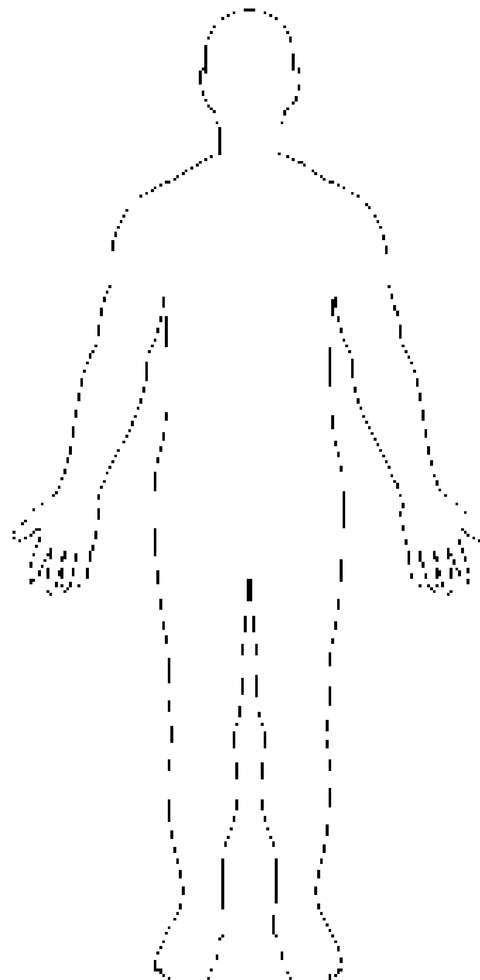
Continued on other side

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 ____