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

Date_____Patient Name_____DOB_____
Sex_____ Height_____Weight_____PCP_____Age_____Weight Limit 400lb
Procedure:_____
Diagnosis:_____
Clinical History: _____
Spec Dr: _____ Outside Order Scanned In Yes/No

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? **NEED 6 wk Creat.**.....	____	____
Do you have an insulin pump or a continuous glucose monitor……	____	____
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?…….	____	____
Any previous diagnostic studies related to this issue……	____	____
If yes, location and date_____		
_____		

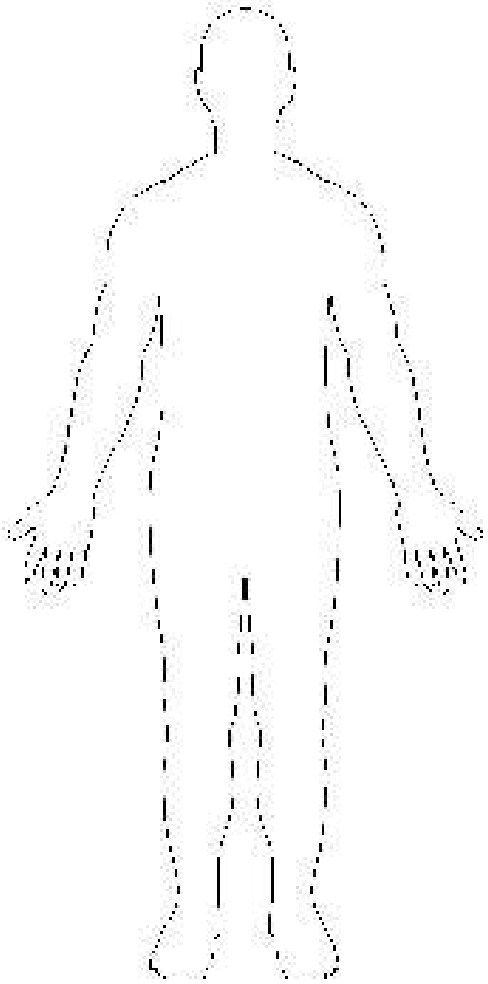
THE FOLLOWING ITEMS MAY BE HAZARDOUS OR MAY INTERFERE WITH THE MRI EXAMINATION BY PRODUCING AN ARTIFACT.

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
____ ____ Magnetic Eyelashes
____ ____ On Oxygen
____ ____ Assistive devices needed? Wheelchair/walker/cane
____ ____ Claustrophobic rx needed Yes/No
____ ____ Is there anything, not already listed, in/on your body that you were not born with?
If yes, please specify_____

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. We strongly recommend that you leave metallic personal belongings at home or locked in your vehicle.

Patient/Guardian signature _____
Date

MD/RN signature _____
Date

RT signature _____
Date