

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date ____/____/____

Patient Number _____

Name _____
name First name Middle Initial

Age _____ Height _____ Weight _____ Last

Date of Birth ____/____/____
month day year

Male Female

Body Part to be Examined _____

Address _____

Telephone (home) (____) ____-____

City _____

Telephone (work) (____) ____-____

State _____ Zip Code _____

Reason for MRI and/or Symptoms _____

Referring Physician _____

Telephone (____) ____-____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? No Yes

If yes, please indicate the date and type of surgery:

Date ____/____/____ Type of surgery _____

Date ____/____/____ Type of surgery _____

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? No Yes

If yes, please list:

	Body part	Date	Facility
MRI	_____	____/____/____	_____
CT/CAT Scan	_____	____/____/____	_____
X-Ray	_____	____/____/____	_____
Ultrasound	_____	____/____/____	_____
Nuclear Medicine	_____	____/____/____	_____
Other	_____	____/____/____	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? No Yes

If yes, please describe: _____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? No Yes

If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? No Yes

If yes, please describe: _____

6. Are you currently taking or have you recently taken any medication or drug? No Yes

If yes, please list: _____

7. Are you allergic to any medication? No Yes

If yes, please list: _____

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? No Yes

9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? No Yes

If yes, please describe: _____

For female patients:

10. Date of last menstrual period: ____/____/____ Post menopausal? No Yes

11. Are you pregnant or experiencing a late menstrual period? No Yes

12. Are you taking oral contraceptives or receiving hormonal treatment? No Yes

13. Are you taking any type of fertility medication or having fertility treatments? No Yes

If yes, please describe: _____

14. Are you currently breastfeeding? No Yes

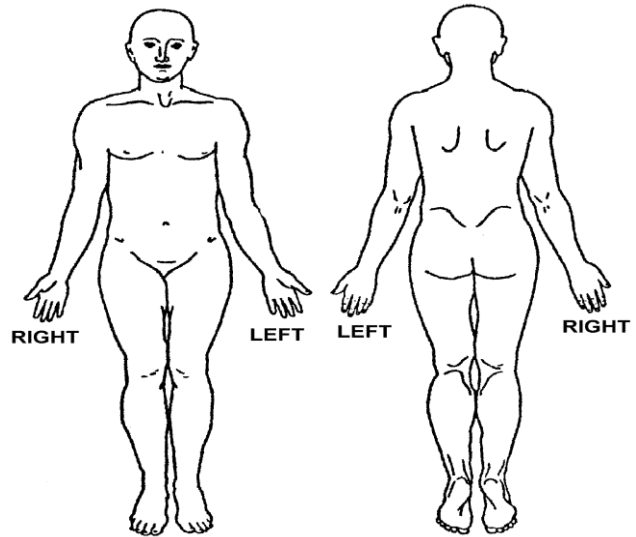


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. The MR system magnet is **ALWAYS** on.

Please indicate if you have any of the following:

- Yes No Aneurysm clip(s)
 - Yes No Cardiac pacemaker
 - Yes No Implanted cardioverter defibrillator (ICD)
 - Yes No Electronic implant or device
 - Yes No Magnetically-activated implant or device
 - Yes No Neurostimulation system
 - Yes No Spinal cord stimulator
 - Yes No Internal electrodes or wires
 - Yes No Bone growth/bone fusion stimulator
 - Yes No Cochlear, otologic, or other ear implant
 - Yes No Insulin or other infusion pump
 - Yes No Implanted drug infusion device
 - Yes No Any type of prosthesis (eye, penile, etc.)
 - Yes No Heart valve prosthesis
 - Yes No Eyelid spring or wire
 - Yes No Artificial or prosthetic limb
 - Yes No Metallic stent, filter, or coil
 - Yes No Shunt (spinal or intraventricular)
 - Yes No Vascular access port and/or catheter
 - Yes No Radiation seeds or implants
 - Yes No Swan-Ganz or thermodilution catheter
 - Yes No Medication patch (Nicotine, Nitroglycerine)
 - Yes No Any metallic fragment or foreign body
 - Yes No Wire mesh implant
 - Yes No Tissue expander (e.g., breast)
 - Yes No Surgical staples, clips, or metallic sutures
 - Yes No Joint replacement (hip, knee, etc.)
 - Yes No Bone/joint pin, screw, nail, wire, plate, etc.
 - Yes No IUD, diaphragm, or pessary
 - Yes No Dentures or partial plates
 - Yes No Tattoo or permanent makeup
 - Yes No Body piercing jewelry
 - Yes No Hearing aid
- (Remove before entering MR system room)
- Yes No Other implant _____
 - Yes No Breathing problem or motion disorder
 - Yes No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE** you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____/____/____

Signature

Form Completed By: Patient Relative Nurse _____

Print name

Relationship to patient

Form Information Reviewed By: _____

Print name

Signature

MRI Technologist Nurse Radiologist Other _____

Central Texas

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MRI: Patient consent for scan with body piercing/jewelry

There are many different types of materials used to make body piercings, jewelry & implants including ferromagnetic and non-ferromagnetic metals. The presence of body piercings/jewelry that are made from ferrous material or conductive property of a certain shape or size may present a problem for a patient in the MRI environment.

Risks include uncomfortable sensations from movement or displacement that may be mild -to- moderate depending on the size of the body piercing /jewelry and its' possible magnetic properties. In extreme cases, serious injury may occur. Body piercings/jewelry made of electrical conductive materials may experience MRI-related heating that may result in excess temperature increase and burns.

By signing this consent you are indicating that you understand the content of this form, you have been given the opportunity to discuss this with your physician and questions have been answered to your satisfaction.

I understand the content of this form and I am willing to proceed with the MRI exam.

PATIENT NAME: _____ **Date:** _____

ORDERING PHYSICIAN _____ **Date:** _____

TECHNOLOGIST _____ **Date:** _____

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MRI Information Sheet

PATIENT NAME: _____

MRI TIME: _____

ARRIVAL TIME:(_____)

*****Please arrive (30) minutes before your scheduled appointment*****

*****8am appointment arrive at (7:45)**

***MRI screen sheets have been supplied to you. Please complete BEFORE you arrive for your MRI appointment. Blue/Black ink.**

Your exam may take anywhere between 30 and 45 min. to complete. Please contact your Physician BEFORE your exam if you feel this amount of time may be difficult for you (i.e. too much pain to be still or claustrophobia).

NO clothes with metal will be allowed in the MRI scan room. (*NO TOMMY COPPER OR LULULEMON). No undergarments that contain metals. We do supply a paper shirt & shorts.

*****IMPORTANT INFORMATION ABOUT YOUR EXAM PLEASE READ*****

The Physicians of Central Texas Sports Medicine & Orthopaedics have a financial interest and/or ownership of our practice. Advance diagnostic imaging, MRI, is offered in our office as a convenience to our patients. Please know that you may have your diagnostic imaging procedures at another facility if you so chose. The Physicians Centre Hospital, CHI St. Joseph's Hospital, and other facilities provide Imaging services, such as MRI, to our patients.

If you have any implanted devices or METAL of any kind in or on your body you MUST inform the office BEFORE your appointment.

(This includes body piercings that cannot be removed)

**** If you have a: ___Pacemaker and/or Defibrillator ___Aneurysm clips (used in brain surgery) You cannot have a MRI and should not enter the MRI environment.**

**If you have any questions or concerns regarding your MRI exam please ask the technologist*.*

Note: MRI exams are read by a Radiologist. CTSM sends MRI exams to Bryan Radiology & Assoc., to be interpreted. The reading fee is separate from the MRI exam. Any questions regarding the fee, please call Bryan Radiology (979)776-8291