MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____/_____/_____ Patient Number ______________________

Name ____ Age ________ Height ________ Weight ________
Last name First name Middle Initial

Date of Birth _____/_____/_____ Male Female Body Part to be Examined _________________________
month day year

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.

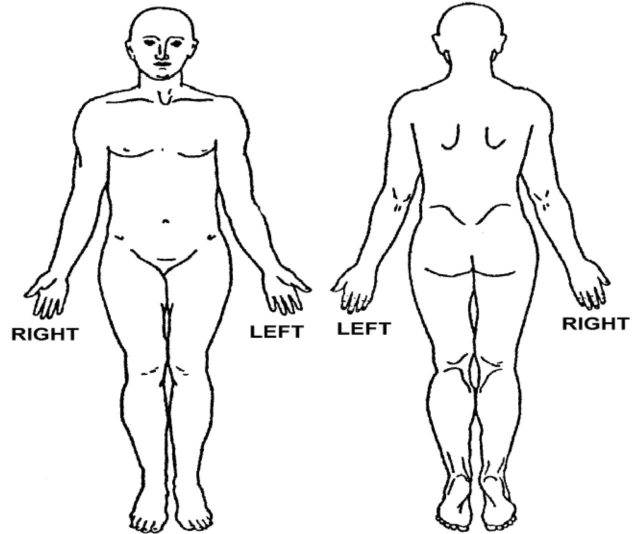
Please indicate if you have any of the following:

- ❑ 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
Sports Medicine & Orthopaedics
A part of Brazos Valley Physicians Alliance

3121 University Drive East, Suite 100 Bryan, Texas 77802 Fax (979) 776-1372 Phone (979) 776-0169 www.centexsportsmedicine.com

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 PHYSCIAN____ **Date:**______________

TECHNOLOGIST____ **Date:** ______________

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MRI Information Sheet

PATIENT NAME: ______________________________ **MRI TIME: ___________________**
ARRIVAL TIME:(_______________)

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

*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