Denver Integrated Imaging

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____/_____/_____

Name _____ Age _____ Height _____ Weight _____
Last name First name

Date of Birth _____/_____/_____ Male Female Body Part to be Examined_____

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, or seizures? No Yes
   If yes, please describe: _____

Please indicate if you have any of the following: (Please circle Yes or No)

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

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

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.
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. 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.

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 _____/_____/_____

Form Completed By: _____ _____
Print name Relationship to patient

Please read and sign if you are also to have an Mri with contrast.

Consent for Intravenous Contrast Agent

Your doctor has ordered your Mri to be performed with an injectable contrast agent, to be administered to you intravenously (in the vein). It is nearly completely eliminated in the urine with 24 hours after injection. Its primary use is to provide contrast enhancement and make it easier to see areas of concern or interest, such as blood vessels or scar tissue.

I consent to intravenous injection of gadolinium based contrasting agent. I understand that as with any medication, including theses compounds, there is a risk of physical reactions. These have been explained to me and I consent to having this procedure.

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