Anne Arundel Diagnostics Imaging

MRI SCREENING FORM

Patient Name:_____ Referring Physician:_____

Date of Birth:_____/_____/_____ Age:_____ Height:_____ Weight_____

***DO ANY OF THE FOLLOWING APPLY TO YOU? Pacemaker/Defibrillator ____YES ____NO**

IF YOU CHECKED "YES" TO HAVING A PACEMAKER/DEFIBRILLATOR, STOP AND IMMEDIATELY NOTIFY THE MRI TECHNOLOGIST

Implanted Metal or Foreign Body ___YES ___NO

BB, Bullet, or Shrapnel ___YES ___NO

Sheet Metal Work ___YES ___NO

Brain Surgery ___YES ___NO

Medication Pump/Tens Unit ___YES ___NO

Pregnant/Possibly Pregnant ___YES ___NO

IF YOU CHECKED "YES" TO ANY OF THE ABOVE, STOP AND INFORM THE MRI TECHNOLOGIST "BEFORE" THE START OF YOUR EXAM

Have you had a previous MRI scan? ___YES ___NO If yes, of what? _____

Have you had any other studies related to this condition? ___YES ___NO If yes, what exam? _____

Personal history of cancer/tumors? ___YES ___NO If yes, specify_____

List all prior surgeries:_____

Have you had any surgeries within the last eight weeks? ___YES ___NO. If yes, what type of surgery _____

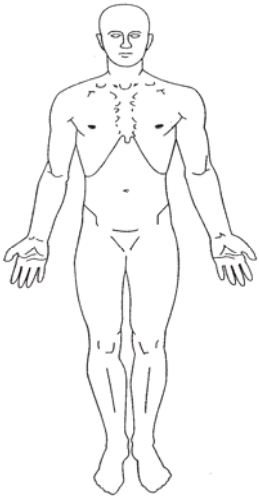
Symptoms related to today's exam_____

If you had an injury, when and how did it occur_____

BRAIN MRI PATIENTS: Check all that apply: ___Headache ___Seizure ___Hearing Loss ___Stroke ___Bleed ___Dizziness ___Ringing in Ears
Any changes in: ___Speech ___Coordination ___Walking ___Memory ___Facial Movement ___Vision

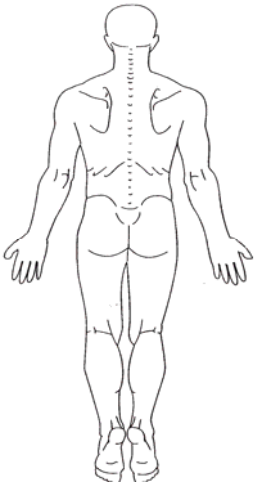
SPINE MRI PATIENTS: Check all that apply: ___ Neck pain ___Back pain **Numbness in:** ___Arm(s) ___Leg(s) **Pain radiates to** ___Left ___Right **How far down does pain radiate to** ___Shoulder ___Elbow ___Hand ___Hip ___Thigh ___Knee ___Foot

R **L**



Please mark the figures in the location of any symptoms.

L **R**



***Please complete the reverse side of this form.**

IMPORTANT INFORMATION

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING. If you answer "Yes" to any of the below questions, DO NOT ENTER the MRI room until the MRI technologist has reviewed this form.

YES	NO	
		Aneurysm Clip(s)
		Cardiac Pacemaker
		Implanted cardioverter defibrillator (ICD)
		Electronic implant or device
		Magnetically activated implant or device
		Neurostimulation system
		Spinal cord stimulator
		Cochlear, otologic, or other ear implant
		Metallic stent, filter, or coil
		Internal electrodes or wires
		Bone growth/bone fusion stimulator
		Any implanted magnet including implants held in place by a Magnet
		Implanted drug delivery system (e.g.: insulin or pain pump, etc.)
		Any type of prosthesis (eye, penile, etc.)
		Artificial or Prosthetic Limb
		Shunt (spinal or intraventricular)
		Swan-Ganz or thermodilution catheter
		Vascular access port and/or catheter
		Tissue expander (e.g. Breast)
		Surgical staples, clips, or metallic sutures
		Any Metallic Fragment or Foreign Body: Bullet, Shrapnel, Buckshot, etc.
		Copper or silver infused underwear or any type of metal on underwear
		Heart Valve Prosthesis
		Joint replacement (hip, knee, etc.)
		Any Orthopedic or Spine Implants: Bone/Joint Pin, Rods, Screws, Clips, Plates, Wire, etc.
		IUD, Diaphragm, or pessary
		Are you wearing deodorant, lotion or powder?
		Tattoo or permanent makeup
		Body piercing jewelry
		Wire Mesh implant
		Dentures or partial plates
		Medication Patch (e.g.: Nicotine, Nitroglycerine, etc.)
		Radiation seeds or implants
		Hearing Aid (Remove before entering MR system room)
		Feraheme treatment
		Eyelid spring/wire or scleral buckle

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

Please consult with the MRI Technologist if you have any questions or concerns **BEFORE** you enter the MRI scan room.

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

Patient Signature: _____ Date: _____

Technologist Signature: _____ Date: _____