Please bring this form to your MRI appointment at
9828 E. Shannon Woods Cir, Ste 100, Wichita, Ks, 67226
P: 316-631-1600 // F: 316-631-1617

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Today's Date:____/____/_____ Chart #_____

Name_____Age:_____Height:_____Weight:_____

Date of Birth: ____/____/_____ Gender: M F AOA Physician:_____

Address:_____ Phone - home:_____work:_____cell:_____
City:_____ State:_____ Zip:_____

Body Part to be examined:_____
Reason for MRI Symptoms:

_____

_____

Patient History

1. Have you had prior surgery on the area being scanned? ☐ No ☐ Yes
   If yes, please describe:_____

2. Have you had any prior diagnostic imaging study
   (MRI, CT, Ultrasound, X-rays) of the body part being scanned today? ☐ No ☐ Yes

   If yes, please list: Study_____ Date___/___/_____ Facility:_____
   Study_____ Date___/___/_____ Facility:_____

3. Have you ever had an injury to the eyes involving a metallic object or fragment (metallic slivers, shavings, foreign body , etc)? ☐ No ☐ Yes

4. Have you ever been injured by a metallic object or foreign body (bullet, BB, shrapnel, etc)? ☐ No ☐ Yes
   If yes, please describe:_____

5. Do you weigh more than 440 pounds? ☐ No ☐ Yes

For Female Patients:

6. Are you pregnant, or is there a possibility of you being pregnant? ☐ No ☐ Yes

7. Are you currently breastfeeding? (note esp if contrast study) ☐ No ☐ Yes

Note: See separate form if your MR procedure is a contrast study

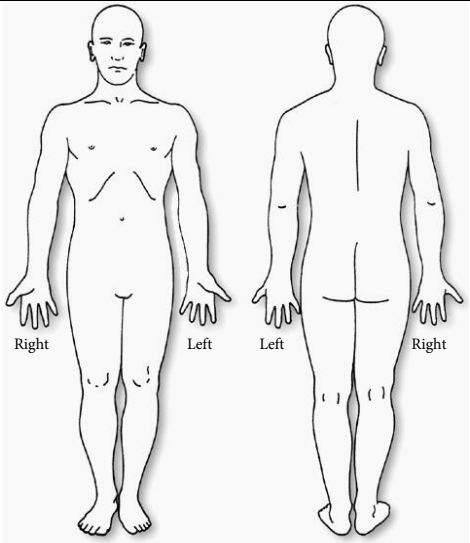
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR, angiography, functional MRI, MR spectroscopy). **DO NOT ENTER** the MR system room or MR environment if you have any question or concerns regarding an implant, device, or 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	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	Breathing problem or motion disorder
☐ Yes	☐ No	Claustrophobia
☐ Yes	☐ No	Other implant_____

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.

Please mark on the figures 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 questions or concerns **BEFORE** you enter the MR system room.

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 the person completing the form:_____ Date:_____
Signature

Form completed by: ☐ Patient ☐ Relative ☐ Nurse/Med Staff _____ _____
Print name Relationship to patient

TO BE COMPLETED BY OFFICE STAFF

Form information reviewed by:_____ _____
Print name Signature

☐ MRI Technologist ☐ Nurse/Med Staff ☐ Radiologist ☐ Other_____