Ortho Georgia Magnetic Resonance (MR) Procedure Screening Form - MRI

Please fill in the form entirely. If you have any questions, **the technologist will go over the form with you before your MRI Scan**. Please return completed form to the RADIOLOGY window. A technologist will be with you shortly. Thank you!

Date _____/_____/_____ Name _____ Male □ Female □
Last name First name Middle Initial

Age _____ Date of Birth _____/_____/_____ Weight_____ Body Part to be Examined_____
Month Day Year

Reason for MRI (injury, accident, work related) and/or Symptoms (pain, numbness, tingling, how long):

_____

1. Have you had prior surgery or an operation **on this area, ever?** If yes, please indicate below □ No □ Yes
Date _____/_____/_____ Type of surgery_____
Date _____/_____/_____ Type of surgery_____

2. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? If yes, please describe:_____ □ No □Yes

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

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 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
□Yes □No For females: Are you pregnant?

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.

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: □ MRI Technologist Initials _____