

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 _____