Pain Specialists
Neurology Specialists
Clinical Trials of SC

MRI SCREENING FORM

Patient Name: _____DOB: _____ Weight: _____
Sex: M / F

THESE ITEMS CAN INTERFERE WITH MR IMAGING AND SOME CAN BE HAZARDOUS TO YOUR SAFTEY
Please check **Yes** or **No** to each item

Have you ever had:	An injury to your eye involving metal?	YES		NO	
	A metallic fragment or foreign body in your head, face, neck or body?	YES		NO	
If yes to either questions above, were you tested to ensure all metal was removed?		YES		NO	

SURGICAL IMPLANTS

	YES	NO		YES	NO
Cardiac Pacemaker			Aneurysm Clips		
Pacemaker Wires			Neurostimulator		
Electronic Implant or Device			Implanted Cardiac Defibrillator (ICD)		
Spinal Cord Stimulator			Bone Fusion or Bone Growth Stimulator		
Cochlear, Otologic, or Ear Implant			Tissue Expander (Breast)		
Internal Electrodes or Wires			Magnetically-activated Implant or Device		
Eyelid Spring or Wire			Swan-ganz Thermodilution Catheter		
Cardiac Stent			Clips in Blood Vessel		
Artificial Heart Valves			Implanted Drug Infusion Device/Pump		
Endoscopy with Camera Pill			Venous Umbrella		
Coil, Filter, Wire in Blood			Pessary or Bladder Ring		
Shunt (spinal or cranial)			Any Metallic Fragment or Foreign Body		
Prosthesis (Eye, Penile, etc.)			Transdermal Medication Patches (Nitro, Nicotine)		
Radiation Seeds or Implants			Bone/Joint Pin, Screw, Nail, Wire, Plate, etc.		
Artificial Limb, Joint Replacements			Harrington Rods (spinal)		
Tens Units			Wire Mesh Implants		
Vascular Access Port or Catheter			Surgical Staples, Clips or Metallic Sutures		
IUD or Diaphragm			Tattoo or Permanent Makeup		
Body Piercing Jewelry			Dentures or Partials		
Hearing Aid			Claustrophobic		

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 piercings, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners and clothing with metallic threads. Consult the MRI Technologist **BEFORE** entering the MR exam room if you have any questions. **The MR system magnet is ALWAYS on.**

PREGNANCY STATUS

Are you: Pregnant?	YES	NO	**Possibly Pregnant?**	YES	NO	**Breast Feeding?**	YES	NO
	☐	☐		☐	☐		☐	☐

SKIN WARMING

*****MRI Radiofrequency has the potential to cause tissue heating. The Technologist will take several precautions to avoid this. **Alert the technologist immediately if you notice any heating sensation during your MRI scan.**

TATTOOS AND PERMANENT MAKEUP

*A small number of patients with tattoos have experienced transient skin irritation, swelling, or heating sensations at the site of the permanent colorings in association with MR procedures. **Individuals with tattoos or permanent makeup should inform the Technologist so appropriate precautions can be taken.**

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

Patient/Guardian Signature: _____ Todays Date: _____

Print Name: _____ Technologist Signature: _____

CONTRAST CONSENT

Due to your medical history or as requested by your Physician, an injection of MRI contrast (Gadolinium) may be necessary to aid the radiologist in evaluating your MRI scan. The Food and Drug Administration has approved this agent. A very small percentage of patients receiving Gadolinium may develop a headache or experience mild nausea. As with all medications, there is a slight risk of an allergic reaction. The physicians and staff at Pain Specialists are trained to respond to any emergency situation that may occur within the MRI Department.
Check YES or NO to <u>each</u> item.

DO YOU HAVE	YES	NO	NOTES
Kidney Function Problems	☐	☐	_____
Liver Function Problems	☐	☐	_____
Asthma or any Respiratory Disease	☐	☐	_____
Diabetes	☐	☐	_____

Have you ever had an allergic reaction to MRI/CT contrast? Y / N If yes, what type? _____

Please list **ALL** known allergies_____

☐ I CONSENT to having Gadolinium contrast as needed

☐ I DECLINE having Gadolinium contrast injected at this time

Patient/Guardian Signature_____ Technologist Signature_____