NETWORKradiology
P: 216.291.8480 - F: 216.291.8490

MRI SCREENING / HISTORY FORM

APPT DATE _____ APPT TIME _____

NAME _____ D.O.B._____ ACCT #_____

MRI EXAM_____ CONTRAST _____YES _____NO

ORDERING DOCTOR_____ HEIGHT_____ WEIGHT_____

MRI (Magnetic Resonance Imaging) uses a powerful magnetic field to produce images of the human body. Any metallic object on or within your body could be affected by the magnetic field. Therefore, it is necessary for patients to complete this form before entering the MRI. Be advised, THE MRI SYSTEM IS ALWAYS ON.

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MRI procedure. DO NOT ENTER the MRI scanning room if you have any questions or concerns regarding an implant, device, or object. In some instances you may be asked to provide information regarding your implant/device before the scan can proceed. Remove all metallic objects before entering the scanner (hair pins, piercings, jewelry, pins, watches, etc.) Leave your cell phone, wallet or other personal belongings in the locker or with a companion.

PLEASE CHECK *YES* OR *NO* WHEN ANSWERING THE FOLLOWING QUESTIONS:

PACEMAKER OR RETAINED WIRES / LEADS*	☐ YES	☐ NO	INTRACRANIAL / VASCULAR COILS	☐ YES	☐ NO
IMPLANTED DEFIBRILLATOR (ICD)*	☐ YES	☐ NO	ARTIFICIAL HEART VALVES	☐ YES	☐ NO
ELECTRONIC IMPLANT / DEVICE*	☐ YES	☐ NO	HEARING AIDS	☐ YES	☐ NO
NEUROSTIMULATOR / DEFIBRILLATOR*	☐ YES	☐ NO	VASCULAR CLIPS	☐ YES	☐ NO
INFUSION PUMP / INSULIN PUMP*	☐ YES	☐ NO	HEART STENTS	☐ YES	☐ NO
ANY MAGNETIC IMPLANT*	☐ YES	☐ NO	BRAIN OR SPINAL SHUNT	☐ YES	☐ NO
COCHLEAR OR EAR IMPLANT*	☐ YES	☐ NO	DENTURES / PARTIALS	☐ YES	☐ NO
JOINT REPLACEMENT OR ARTIFICIAL LIMB	☐ YES	☐ NO	DENTAL FILLINGS	☐ YES	☐ NO
ABDOMINAL ANEURYSM SURGERY / GRAFT	☐ YES	☐ NO	SURGICAL CLIPS	☐ YES	☐ NO
METAL PLATES, PINS/SCREWS, RODS, FUSION	☐ YES	☐ NO	BODY PIERCINGS	☐ YES	☐ NO
TATTOO OR PERMANENT MAKEUP	☐ YES	☐ NO			
OTHER DEVICE	☐ YES	☐ NO	IF YES, PLEASE DESCRIBE: _____		

IF YOU MARKED "YES" FOR ANY IMPLANT, HEART VALVE, HEART STENTS, ETC. - WHAT MAKE/MODEL?

_____

COILS AND STENTS ARE TYPICALLY MRI COMPATIBLE. IF THEY ARE RECENT, YOU MAY NEED TO WAIT 6-8 WEEKS AFTER PLACEMENT FOR AN MRI.

HAVE YOU EVER HAD A SURGICAL PROCEDURE OF ANY KIND? _____YES _____NO

IF YES, PLEASE LIST ALL OPERATIONS & APPROXIMATE DATES_____

_____

_____

NETWORKradiology
P: 216.291.8480 - F: 216.291.8490

ACCT #_____

HAVE YOU EVER EXPERIENCED ANY PROBLEM RELATED TO A PREVIOUS MRI PROCEDURE? ☐ YES ☐ NO
(THIS INCLUDES MRI CONTRAST REACTIONS)

IF YES, PLEASE DESCRIBE _____

HAVE YOU EVER EXPERIENCED AN INJURY TO YOUR EYE(S) INVOLVING A METALLIC OBJECT? ☐ YES ☐ NO
(METALLIC SLIVERS, SHAVINGS, FOREIGN BODY, ETC. MAY REQUIRE X-RAY)

IF YES, PLEASE DESCRIBE _____

HAVE YOU BEEN INJURED BY A METALLIC OBJECT? ☐ YES ☐ NO
(BB, BULLET, SHRAPNEL, ETC. MAY REQUIRE X-RAY)

IF YES, PLEASE DESCRIBE _____

DO YOU HAVE A HISTORY OF KIDNEY DISEASE? (BUN AND CREATININE LABS REQUIRED) ☐ YES ☐ NO

ARE YOU A DIABETIC? ☐ YES ☐ NO

ANY HISTORY OF CANCER? ☐ YES ☐ NO
IF YES, WHAT TYPE & LOCATION OF CANCER? _____DIAGNOSED DATE_____

FOR FEMALE PATIENTS:

DATE OF LAST MENSTRUAL PERIOD_____ POST MENOPAUSAL? ☐ YES ☐ NO

ARE YOU PREGNANT? (MRI REQUIRES CLEARANCE FROM OBGYN) ☐ YES ☐ NO

ARE YOU CURRENTLY BREASTFEEDING? (MRI REQUIRES CLEARANCE FROM OBGYN - CONTRAST ONLY) ☐ YES ☐ NO

DO YOU HAVE AN IUD OR DIAPHRAGM? ☐ YES ☐ NO IF YES, WHAT KIND? _____
(MAY NEED TO SEE DOCTOR AFTER MRI TO CHECK DEVICE POSITIONING)

IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING YOUR PROCEDURE PLEASE ASK THE TECHNOLOGIST.

I, (THE UNDERSIGNED) HAVE ANSWERED THE ABOVE QUESTIONS ACCURATELY. I UNDERSTAND THAT ALL METALLIC OBJECTS INCLUDING JEWELRY, CREDIT CARDS, EYEGLASSES, PINS, WATCHES, PHONE, PAGERS, DENTURES, HAIR PINS, ETC. MUST BE REMOVED BEFORE ENTERING THE SCANNING ROOM. MRI PERSONNEL WILL NOT TAKE POSSESSION OF PERSONAL ITEMS. A SECURED LOCATION WILL BE PROVIDED OR ITEMS MAY BE GIVEN TO SOMEONE ACCOMPANYING THE PATIENT.

SIGNATURE OF PATIENT OR GUARDIAN_____ **DATE**_____

SIGNATURE OF NETWORK RADIOLOGY REP (INDICATES REVIEW OF DOCUMENT) _____
ANY AREA MARKED "YES" NEEDS TO BE POINTED OUT TO THE TECHNOLOGIST

SIGNATURE OF MRI TECHNOLOGIST (INDICATES REVIEW OF DOCUMENT) _____
ANY AREA MARKED "YES" HAS BEEN REVIEWED. PATIENTS WILL NOT BE SCANNED IF "YES" HAS BEEN CHECKED FOR AN ITEM MARKED WITH *

NETWORKradiology
P: 216.291.8480 - F: 216.291.8490

NAME _____ DATE_____ ACCT #_____

MRI EXAM_____

DO YOU HAVE PAIN? WHERE? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN & WHERE_____

HOW FREQUENT IS THE PAIN?_____

HAVE YOU HAD OTHER TESTS FOR THIS PRESENT PROBLEM? ☐ YES ☐ NO

IS THIS THE RESULT OF AN INJURY? ☐ YES ☐ NO DATE OF INJURY_____

IF YES, PLEASE EXPLAIN _____

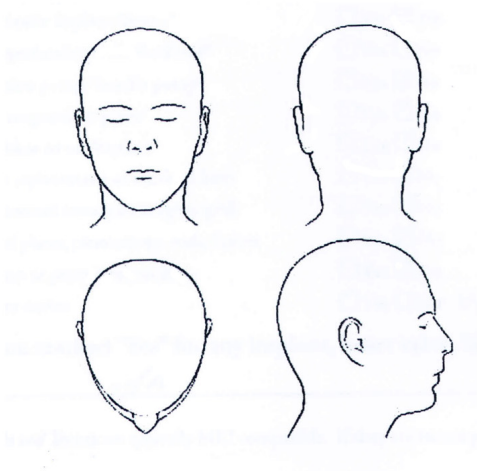
DID YOU TAKE ANY MEDICATION FOR SEDATION TO RELAX YOU TODAY? ☐ YES ☐ NO

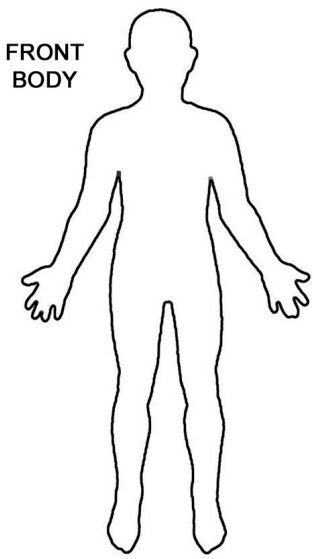
IF YES, WHAT? _____

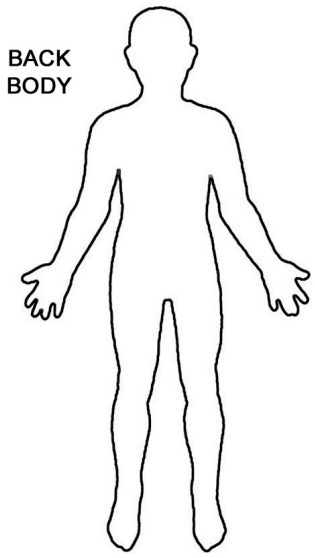
PLEASE CHECK MARK BELOW AND CIRCLE ON THE IMAGE AFFECTED BY PAIN, NUMBNESS, ETC.

STROKE _____ HEAD INJURY _____ FAINTING _____ DIZZINESS _____ HEADACHES _____

HEARING CHANGES _____ VISUAL CHANGES _____ WEAKNESS _____ NAUSEA / VOMITTING _____







SIGNATURE OF PATIENT OR GUARDIAN_____ **DATE**_____

REVIEW AND SIGNATURE OF NETWORK RADIOLOGY TECHNICIAN _____ **DATE**_____