

# MRI SCREENING FORM



SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete  
DOS: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PATIENT #: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ / AGE: \_\_\_\_ / SEX: \_\_\_\_

**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. DO NOT ENTER the MR System room or MR environment if you have any questions or concerns regarding an implant, device or object. Consult the MRI technologist or Radiologist BEFORE entering the MR room. The MR system magnet is ALWAYS ON.

## **Please indicate if you have any of the following:**

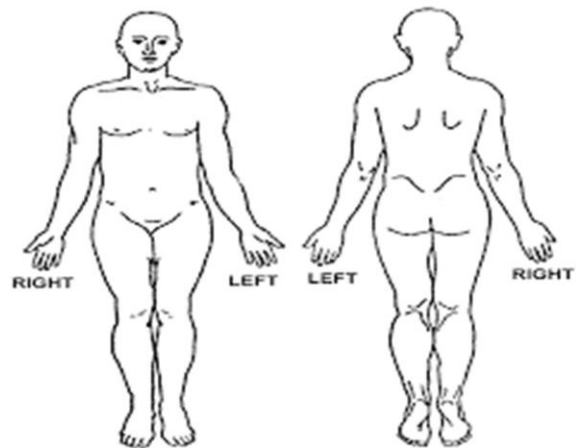
- ☐ Yes ☐ No Aneurysm clip(s)
- ☐ Yes ☐ No Cardiac pacemaker
- ☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
- ☐ Yes ☐ No Electronic implant or device
- ☐ Yes ☐ No Magnetically-activated implant or device
- ☐ Yes ☐ No Neurostimulator or bone stimulator
- ☐ Yes ☐ No Brace, splint or other joint support
- ☐ Yes ☐ No Internal electrodes or residual wires
- ☐ Yes ☐ No Cochlear, otologic, or other ear implant
- ☐ Yes ☐ No Insulin or other infusion pump
- ☐ Yes ☐ No Morphine infusion pump
- ☐ Yes ☐ No Penile prosthesis
- ☐ Yes ☐ No Heart valve prosthesis
- ☐ Yes ☐ No History of eye or retina surgery
- ☐ Yes ☐ No Artificial or prosthetic limb
- ☐ Yes ☐ No Abdominal aortic aneurysm stent graft
- ☐ Yes ☐ No Shunt (spinal or intraventricular)
- ☐ Yes ☐ No Radiation seeds or implants
- ☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerin)
- ☐ Yes ☐ No Any metallic fragment or foreign body
- ☐ Yes ☐ No Wire mesh implant
- ☐ Yes ☐ No Breast tissue expander
- ☐ 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
- ☐ Yes ☐ No Dentures or partial plates
- ☐ Yes ☐ No Body piercing jewelry
- ☐ Yes ☐ No Hearing aid (Remove before entering)
- ☐ Yes ☐ No Breathing problem or motion disorder
- ☐ Yes ☐ No Claustrophobia (Afraid of confined spaces)
- ☐ Yes ☐ No **Have you ever been injured by any metallic object (e.g. bullet, shrapnel, BB, etc.)?**
- ☐ Yes ☐ No **Have you ever had an eye injury involving a metallic object (e.g. metallic slivers, shavings, etc.)?**

## **IMPORTANT INSTRUCTIONS**

Before entering the MR environment or MR system room, you must remove ALL metallic objects including cell phones, **ALL JEWELRY**, hearing aids, dentures, partial plates, keys, eyeglasses, hair pins, barrettes, body piercings, watches, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools. Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE YOU ENTER THE MRI SYSTEM ROOM. Lockers will be provided before entering the MRI Suite (Glasses, dental work, shoes can remain with you until you enter the room).

**For your safety, you will be asked to change into a gown.**

PLEASE MARK ON THE FIGURE BELOW THE LOCATION OF IMPLANTS OR METAL INSIDE OF OR ON YOUR BODY



Note: You may be advised to wear earplugs or other hearing protection during the MRI to prevent possible problems related to noise. MRI is generally a safe procedure. Qualified medical personnel will be present throughout procedure.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form; 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: \_\_\_\_\_

If Form Completed By Someone Other than the Patient (Print name/Relationship): \_\_\_\_\_

MRI Technologist: \_\_\_\_\_

# MRI ORTHO HISTORY

Patient MUST Complete  
DOS: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PATIENT #: \_\_\_\_\_  
PATIENT NAME: \_\_\_\_\_  
DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ / AGE: \_\_\_\_ / SEX: \_\_\_\_

**\*\*\* Please answer the following questions about your medical history to the best of your ability. Our Radiologists and staff will use the information you provide to select the most appropriate imaging techniques and to interpret the examination in order to best serve you! If you have any questions, please do not hesitate to ask. \*\*\***

Please describe the symptoms you are having that led to this test.  
If applicable, please tell us where and which side (RIGHT/LEFT).

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

Describe here: \_\_\_\_\_

**Where** are your symptoms in this area? (e.g. front, back, inner, outer, top, bottom, all)? \_\_\_\_\_

**How long** have you had these symptoms (problems)? \_\_\_\_\_

☐ Yes ☐ No - Was this a result of trauma/injury? If yes, please describe what happened: \_\_\_\_\_

☐ Yes ☐ No - Have you ever had surgery on the part of your body being imaged? If yes, please describe the surgery: \_\_\_\_\_

☐ Yes ☐ No - Do you have a history of cancer? If yes, what type and when was it diagnosed (month/year)? \_\_\_\_\_

If yes, describe how your cancer was treated (radiation/gamma knife/proton/chemo/surgery)? Please list approx. dates of treatment/procedures \_\_\_\_\_

Please list what/when/where you've had prior studies of this body part (MRI/CT/XRays/US/Angio/Nuclear Med)? \_\_\_\_\_

<b>FOR WOMEN:</b> Date of last menstrual period: _____	Are you post menopausal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you experiencing a late menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any chance that you are pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you taking any form of birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No -- If yes, list: _____	

## TECHNOLOGIST USE ONLY

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
MRI Technologist: \_\_\_\_\_ Ext: \_\_\_\_\_

I attest that the above information, including technologist's comments, is correct to the best of my knowledge. I have read and understand the contents of this form. I have 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: \_\_\_\_\_

If Form Completed By Someone Other than the Patient (Print name): \_\_\_\_\_

Relationship: \_\_\_\_\_