NATCHITOCHES IMAGING CENTER
MRI PATIENT SCREENING FORM

Patient Name ______________________________ Date ____________

Date of Birth ____________ Age ______ Sex M/F Height ______ Weight ______ Physician ____________

Symptoms pertaining to exam ______________________________

Allergies ______________________________

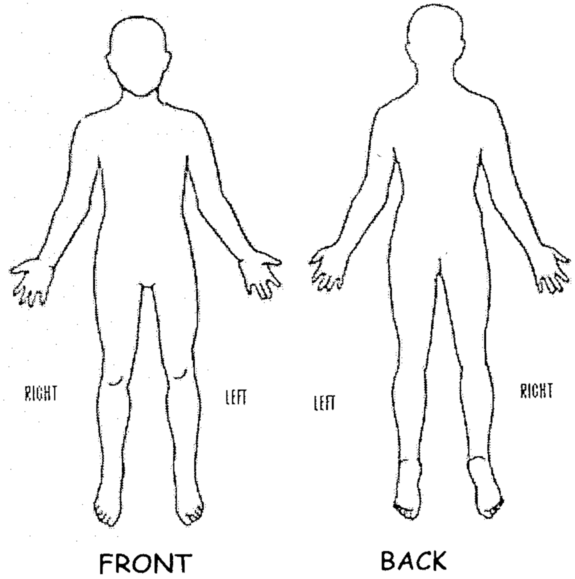
PLEASE REMOVE ALL HAIR ACCESSORIES - PINS, CLIPS, BARETTES, ETC...

Patient History

MRI cannot be performed if "yes" is answered to (**) questions. All (*) answered questions must be referred to the radiologist.

**Pacemaker, pacemaker wires ________ Yes ________ No
**Defibrillator ________ Yes ________ No
**Brain aneurysm clips ________ Yes ________ No
**Neurostimulator or bone stimulator ________ Yes ________ No
*Heart stents ________ Yes ________ No
*Artificial heart valve ________ Yes ________ No
*Implanted infusion pump ________ Yes ________ No
*Prior ear, eye, or brain surgery ________ Yes ________ No
*Metallic foreign body ________ Yes ________ No
(Gunshot wounds and/or metal shavings in eye)

Metallic implant or prosthesis ________ Yes ________ No
Orthopedic devices ________ Yes ________ No
Surgical clips ________ Yes ________ No
Glitter makeup or tattoos ________ Yes ________ No
Body jewelry ________ Yes ________ No
Braces/dentures/partials ________ Yes ________ No
Claustrophobia ________ Yes ________ No
Medication skin patches (must be removed) ________ Yes ________ No



Have you had prior MRI studies? ________ If yes, what kind? ______________________________
Have you had prior surgery of any kind? ________ If yes, what kind? ______________________________

For female patients:
Are you pregnant? ________ Date of last menstrual period ___/___/___ Are you breastfeeding? ________

Before entering into the MRI environment you will be asked to remove all metallic objects. Any questions, please ask technologist.

Consent: I understand this MRI procedure may require the use of MRI contrast (gadolinium). There is a very small risk of having an allergic reaction associated with the use of this contrast. By signing, I acknowledge the above statements are correct and I give the technologist permission to administer contrast.

______________________________ ______________
Signature of Patient/Representative Date

____
Witness

To be filled out by technologist:

Creatinine ______ Clearance ______ Date of labs ________

Amount and type of contrast used ________________