Centra
All Facilities

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Name: ____ Height: __________ Weight: __________
Last Name First Name Middle Initial

Date of Birth: ____/____/________ Body Part to be Examined: ______________________________

Reason for MRI, Symptoms, Injury and Date: ____

Referring Physician: ______________________ Creatinine: _______ GFR: ________ Date Collected: __________

Technologist Use: IV started by: __________ Location: __________ # of sticks: ________ Medications Reviewed ☐ _____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☐ No ☐ Yes
   If yes, please indicate the date and type of surgery:

   Date ___/___/_____ Type of surgery ______________________________
   Date ___/___/_____ Type of surgery ______________________________
   Date ___/___/_____ Type of surgery ______________________________
   Date ___/___/_____ Type of surgery ______________________________

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.) of body part being scanned today?
   If yes, please list:

Exam and Body Part	Date	Facility
______________________	Date ___/___/_____	______________________
______________________	Date ___/___/_____	______________________
______________________	Date ___/___/_____	______________________

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes
   If yes, please describe: ____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ No ☐ Yes
   Technologist Use: Orbits Cleared by: ______________________________________
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes
   If yes, please describe: ____
6. Do you have a history of cancer? If yes, please describe: ______________________ ☐ No ☐ Yes
   ____
7. Do you have a history of allergic reaction to a contrast medium or dye used for an MRI examination? ☐ No ☐ Yes
   If yes please describe: ____
8. Do you have a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant? ☐ No ☐ Yes
   If yes please describe: ____

For male patients:

9. Do you have a penile implant? ☐ No ☐ Yes

For female patients:

10. Date of last menstrual period: ___/___/_____ Post menopausal? ☐ No ☐ Yes
11. Are you pregnant or suspect you are pregnant ☐ No ☐ Yes
12. Are you currently breastfeeding? Please note if contrast used, a minimal amount enters the breast milk. ☐ No ☐ Yes

Please fax completed forms to:
Lynchburg General Hospital (434) 200-2696
Southside Community Hospital (434) 315-2768
Bedford Memorial Hospital (540) 586-0317
Gretna Medical Center (434) 200-4541

Patient Label

Not part of the permanent medical record