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

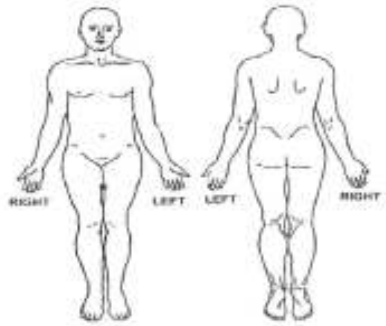
MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, MR spectroscopy). Do not enter the MR system room or MR environment if you have any questions or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- ☐ Yes ☐ No Aneurysm clip(s) or coils
- ☐ Yes ☐ No Cardiac pacemaker or pacing wires
- ☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
- ☐ Yes ☐ No Electronic implant or device
- ☐ Yes ☐ No Magnetically-activated implant or device
- ☐ Yes ☐ No Neurostimulator or spinal cord stimulator
- ☐ Yes ☐ No Head or brain surgery
- ☐ Yes ☐ No Internal electrodes or wires
- ☐ Yes ☐ No Bone growth / bone fusion stimulator
- ☐ Yes ☐ No Cochlear, otologic, or other ear implant
- ☐ Yes ☐ No Insulin or other infusion pump
- ☐ Yes ☐ No Implanted drug infusion device
- ☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)
- ☐ Yes ☐ No Heart valve prosthesis, loop recorder
- ☐ Yes ☐ No Eyelid spring or wire, TriggerFish contacts
- ☐ Yes ☐ No Artificial or prosthetic limb
- ☐ Yes ☐ No Vascular stent, filter, or coil
- ☐ Yes ☐ No Shunt (spinal or intraventricular)
- ☐ Yes ☐ No Vascular access port and/or catheter
- ☐ Yes ☐ No Radiation seeds or implants
- ☐ Yes ☐ No Swan-Ganz or thermodilution catheter
- ☐ Yes ☐ No Medication patch or silver wound dressing
- ☐ Yes ☐ No Any metallic fragment or foreign body
- ☐ Yes ☐ No Wire mesh implant
- ☐ Yes ☐ No Tissue expander (e.g., breast)
- ☐ 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, diaphragm, or pessary
- ☐ Yes ☐ No Dentures or partial plates
- ☐ Yes ☐ No Tattoo or permanent makeup
- ☐ Yes ☐ No Body piercing jewelry
- ☐ Yes ☐ No Hearing aid *(Remove before entering MR system room)*
- ☐ Yes ☐ No Other implant_____
- ☐ Yes ☐ No Small bowel endoscopy capsule
- ☐ Yes ☐ No Ventilator

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove <u>all</u> metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any questions BEFORE you enter the MR system room.

NOTE: You will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and 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:__/_____/_____

Form Completed By: ☐Patient ☐Relative ☐POA _____
Print name Relationship to patient

RN or Pre-screening signature:_____ Date:_____

MRI Technologist signature:_____ Date:_____

Technologist remarks:_____

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