Spencer Open MRI Screening Forms

Full Name: _____ Weight: _____ Date: _____

Date of Birth: _____ ☐ Male ☐ Female Body part to be examined: _____

Reason for MRI and/or symptoms: _____

Ordering Physician: _____ Daytime Phone: _____

Date of injury: _____

Is this MRI related to: ☐ Personal Injury ☐ Work Related ☐ Auto ☐ Chronic

**** If your MRI today is related to a work or auto accident, please notify the front desk ****

1. Have you had prior surgery (for example arthroscopy, endoscopy, joint replacement) of any kind? ☐ Yes ☐ No

   If yes, please indicate the date and type of surgery: _____

2. Have you had any of the following procedures performed on the body part we are examining today? ☐ Yes ☐ No

If yes, please list:	Body Part	Date	Facility
MRI	_____	_____	_____
CT/CAT SCAN	_____	_____	_____
X-Ray	_____	_____	_____
Ultrasound	_____	_____	_____
Nuclear Medicine/Bone Scan	_____	_____	_____
Other _____	_____	_____	_____

3. Have you experienced any problems related to a previous MRI examination or MR procedure? ☐ Yes ☐ No

   If yes, please explain: _____

4. Have you had an injury to eye involving a metallic object or fragment (e.g. metallic slivers, shaving, foreign body, etc) ? ☐ Yes ☐ No

   If yes, please explain: _____

5. Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel, etc.)? ☐ Yes ☐ No

   If yes, please explain: _____

6. Do you have history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or x-ray examination? ☐ Yes ☐ No

   If yes, please explain: _____

7. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, failure, or transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? ☐ Yes ☐ No

   If yes, please explain: _____

For Female Patients Only

8. Date of last menstrual period: _____ Post Menopausal? ☐ Yes ☐ No
9. Are you pregnant or experiencing a late menstrual period? ☐ Yes ☐ No
10. Are you taking oral contraceptives or receiving hormonal treatment? ☐ Yes ☐ No
11. Are you taking any type of fertility medication or having fertility treatments? ☐ Yes ☐ No

    If yes, please explain: _____

12. Are you currently breastfeeding? ☐ Yes ☐ No

Technologist notes: _____

_____

Contrast Details:

1. Type _____ 2. Amount Given _____ cc's 3. Expiration Date _____ 4. Lot #_____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, 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)
☐ Yes ☐ No Cardiac pacemaker
☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
☐ Yes ☐ No Electronic implant or device
☐ Yes ☐ No Neurostimulation system
☐ Yes ☐ No Spinal cord stimulator
☐ 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
☐ Yes ☐ No Eyelid spring or wire
☐ Yes ☐ No Artificial or prosthetic lib
☐ Yes ☐ No Metallic 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 (nicotine, Nitroglycerine)
☐ Yes ☐ No Any metallic fragment or foreign body
☐ Yes ☐ No Wire mesh implant
☐ Yes ☐ No Tissue expander (breast, etc.)
☐ 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 Hear aid (remove before entering MR system room)
☐ Yes ☐ No Breathing Problem or motion disorder
☐ Yes ☐ No Claustrophobia
☐ Yes ☐ No Other implant: _____

Before entering the MR environment or MR system room, you must remove all 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, and clothing with metallic threads.

Please consult MRI technologist or radiologist if you have any question or concern BEFORE you enter the MR system room.

SPENCER OPEN MRI

Note: you may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I have read and understood the questions above; my responses are correct to the best of my knowledge. I understand that it is my responsibility to inform Spencer Open MRI of any metal fragments and/or devices that may be in my body and that failing to do so may cause serious bodily injury or be life threatening. I agree that should I have any metal in my body and elect to proceed with the MRI, I release Spencer Open MRI and Orthopaedics, PC from any and all liability for any injury.

Signature of Person Completing form: _____ Date: _____
Signature

Form completed by: ☐ Patient ☐ Relative ☐ Clinic Staff _____ _____
Print Name Relationship/Title

Form Information Reviewed by: _____ _____
Print Name Signature

☐ MRI Technologist ☐ Clinic Staff ☐ Radiologist ☐ Other _____