SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

MAGNETIC RESONANCE (MR) PROCEDURE PATIENT SCREENING FORM

Date: _____/_____/_____ Patient Number: _____

Nov. 2015

Name: Age: Height: Weight:

Date of Birth: / / Male ☐ Female ☐ Body Part to be Examined:

The MR system has a very strong magnet field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices or objects. Therefore, all individuals are required to fill out this form BEFORE entering the MR environment or MR system room.

BE ADVISED, THE MR SYSTEM MAGNET IS ALWAYS ON.

	YES	NO
1. Do you have a cardiac pacemaker?	☐	☐
2. Do you have any metal in your body?	☐	☐
3. Do you have an electronic implant or device?	☐	☐
4. Do you have a cochlear implant or implanted hearing device?	☐	☐
5. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? If yes, please indicate the date and type of surgery: Date: ____/____/____ Type of Surgery: _____	☐	☐
6. Have you experienced any problem related to a previous MRI exam or MR procedure?	☐	☐
7. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? If Yes, please describe: _____	☐	☐
8. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? If Yes, please describe: _____	☐	☐
9. Are you currently taking or have you recently taken any medication or drug? If Yes, please list: _____	☐	☐
10. Are you allergic to any medication? If Yes, please list: _____	☐	☐
11. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a medium or dye used for an MRI, CT, or X-ray examination?	☐	☐
12. Do you have anemia or any disease(s) that affect your blood, a history of renal (kidney) disease, or seizures? If Yes, please describe: _____	☐	☐
FOR FEMALE PATIENTS		
13. Date of last menstrual period: ____/____/____	☐	☐
14. Are you pregnant or experiencing a late menstrual period?	☐	☐
15. Are you currently breastfeeding?	☐	☐

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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 question 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)
☐	☐	Cardiac Pacemaker
☐	☐	Implanted Cardioverter Defibrullator (ICD)
☐	☐	Electronic Implant or Device
☐	☐	Magnetically Activated Implant or Device
☐	☐	Neurostimulation System
☐	☐	Spinal Cord Stimulator
☐	☐	Internal Electrodes or Wires
☐	☐	Bone Growth / Bone Fusion Stimulator
☐	☐	Cochlear, Otologic, or Other Ear Implant
☐	☐	Insulin or Other Infusion Pump
☐	☐	Implanted Drug Infusion Device
☐	☐	Any Type of Prosthesis (Eye, Penile, Etc.)
☐	☐	Heart Valve Prosthesis
☐	☐	Eyelid Spring or Wire
☐	☐	Artificial or Prosthetic Limb
☐	☐	Metallic stent, Filter or Coil
☐	☐	Shunt (Spinal or Intraventricular)
☐	☐	Vascular Access Port and/or Catheter
☐	☐	Radiation Seeds or Implants
☐	☐	Swan-Ganz or Thermodilution Catheter
☐	☐	Medication Patch (Nicotine, Nitroglycerine)
☐	☐	Any Metallic Fragment or Foreign Body
☐	☐	Wire Mesh Implant
☐	☐	Tissue Expander (e.g., Breast)
☐	☐	Surgical Staples, Clips, or Metallic Sutures
☐	☐	Joint Replacement (Hip, Knee, Etc.)
☐	☐	Bone/Joint Pin, Screw, Nail, Wire, Plate, Etc.
☐	☐	IUD, Diaphragm, or Pessary
☐	☐	Dentures or Partial Plates
☐	☐	Tattoo or Permanent Makeup
☐	☐	Body Piercing Jewelry
☐	☐	Hearing Aid (Remove Before Entering MR System Room)
☐	☐	Other Implant _____
☐	☐	Breathing Problem or Motion Disorder
☐	☐	Claustrophobia

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 Information Reviewed By: _____ Signature: _____

☐ MRI Technologist ☐ Radiologist ☐ Other: _____