ALEXANDERORTHOPAEDICASSOC.

MRI scheduling 727-547-4700 x 111

MRI PATIENT SCREENING FORM

NOTE: if participant has completed this form for a previous MRI exam and there have been no changes to participants medical history, indicate information has been mimed by entering today's date and initials below.

Date: _____/_____/_____ AOA Chart Number_____ Male/Female/Non-Binary

Name: _____ Date of Birth: ____/____/____ Age_____Weight_____ Height_____

Exam ordered/Body part_____ Ordering Physician_____

PATIENT SYMPTOMS: _____

MRI Technologist note: _____

_____

Have you had a prior MRI or CT exam of today's testing?

MRI	CT or Xray's
Facility/date_____	_____
Facility/date_____	_____

1. **Please list any prior surgery or operations of any kind, including arthroscopy, endoscopy etc. with approximate date.**

Surgery_____Date_____Surgery_____ Date_____

Surgery_____Date_____Surgery_____ Date_____

Surgery_____Date_____Surgery_____ Date_____

Surgery_____Date_____Surgery_____ Date_____

2. **Have you had an injury to the eye involving a metallic object or fragment. If yes, please explain**. ☐ Yes ☐ No

_____

3. **Have you ever been injured by a metallic foreign object (BB, Bullet, Shrapnel, etc.)? If yes, please explain**. ☐ Yes ☐ No

_____

4. **Are you wearing any type of medication patch or glucose monitor? If yes, please explain**. ☐ Yes ☐ No

_____

5. **Have you ever had complications from MRI contrast in the past? If yes, please explain**. ☐ Yes ☐ No

_____

6. **Are you pregnant or could possibly be pregnant?** ☐ Yes ☐ No

Information has been reviewed, any changes since previous MRI study are noted.

Date_____ Patient initials_____ MRI Screener _____

Date_____ Patient initials_____ MRI Screener _____

Date_____ Patient initials_____ MRI Screener _____

WARNING:

Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI procedure. **DO NOT ENTER** the MRI Scan room or MRI environment if you have any questions or concerns regarding an implant, device or object. Consult the MRI Technologist BEFORE entering the MRI room. The MRI is **ALWAYS ON.**

The following items may be harmful to you during your MR scan and may interfere with the MR examination. You must provide a **"Yes" or "No" answer for every item**.

☐ YES	☐ NO	Brain Aneurysm clip or coil
☐ YES	☐ NO	Cardiac pacemaker or wires
☐ YES	☐ NO	Implanted cardioverter defibrillator (ICD) or cardiac loop recorder
☐ YES	☐ NO	Neurostimulator, diaphragmatic stimulator, deep brain stimulator, vagus nerve stimulator, bone growth stimulator, spinal cord stimulator or bladder stimulator
☐ YES	☐ NO	Cochlear implant
☐ YES	☐ NO	Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine, glucose monitor)
☐ YES	☐ NO	Artificial heart valve, stent or coil
☐ YES	☐ NO	Any type of coil, filter or stent
☐ YES	☐ NO	Any type of ear implant
☐ YES	☐ NO	Penile implant or radiation seeds
☐ YES	☐ NO	Artificial eye or Eyelid spring and/or eyelid weight
☐ YES	☐ NO	Any type of implant held in place by a magnet
☐ YES	☐ NO	Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, PICC line)
☐ YES	☐ NO	Tissue Expander (e.g., breast)
☐ YES	☐ NO	IUD, diaphragm or pessary
☐ YES	☐ NO	Shunt (spinal or intraventricular)
☐ YES	☐ NO	Artificial or prosthetic limb
☐ YES	☐ NO	Surgical staples or clips
☐ YES	☐ NO	Joint replacements (hip, knee, shoulder)
☐ YES	☐ NO	Bone/joint screws, pin, nail or wirers
☐ YES	☐ NO	Hearing aid or dentures/bridges
☐ YES	☐ NO	Tattoo or permanent makeup
☐ YES	☐ NO	Wig or hair extensions
☐ YES	☐ NO	Body piercings
☐ YES	☐ NO	Magnetic cosmetics (magnetic eyelashes, magnetic nail polish etc.)
☐ YES	☐ NO	Are you Claustrophobic

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and MRI procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date_____/_____/_____

Form Completed by ☐ Participant ☐ Relative ☐ Other_____

MRI Technologist_____ Date _____/_____/_____

Physician/Radiologist (if required) _____ Date_____/_____/_____