MRI SCREENING SHEET

Mobile Fixed

Date______________________Time_________________________________Exam_______________________

Patient Name____ DOB___________________
Phone (H)______________________ (W)__________________ MD _________________________
Insurance_____________________________Precert_________________________

Pt Weight____________ Ambulatory? _____________ Claustrophobic? Y N On 02? Y N

Clinical Information____
____
____

Previous Related Exams____
Previous Surgery? Brain Heart Spine (C T L) Other
Chest X-ray cleared? ____________
____

Have you ever worked with metal? (grinding, machinist, metalworker)	Yes	No
Have you ever had a metal injury to the eye?	Yes	No
Have you been injured by a metallic object? (bullet, BB, shrapnel etc)	Yes	No

Comments:____
Orbit x-ray cleared?________________________
Any chance of pregnancy? Yes or No LMP____________________ Breast Feeding____________________
Gone Through Menopause (breast exams only) ________________________________

Magnetic Safety Checklist	**Phone**	**Tech**
Cardiac Pacemaker	_____	_____
Aneurysm Clip	_____	_____
Neuro or Bone stimulator	_____	_____
Pump for Medication	_____	_____
Vascular stent, filter, coil	_____	_____
Surgical Implants	_____	_____
Cochlear (ear) Implants	_____	_____
Shunt - spinal or Intraventricular	_____	_____
Hearing Aids	_____	_____
Removable Dental Work	_____	_____
Patch for Medication	_____	_____
Personal history of Cancer	_____	_____

What type?___________ Site?_____________________

PROTOCOL
Routine Y N
Gad Y N

Additional Sequences
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____
____
____
____
____
____
Rad__________
Tech______________

Comments____

PATIENT/GUARDIAN Signature____Date____________