Sensible MRI
Making Sense of Healthcare

MRI PATIENT HISTORY AND SCREENING FORM

Patient: ____Date of Birth: ______________________

Sex: Male ☐ Female ☐ Referring Physician: ____

Date of Service: _________________ Height: _____________ Weight: _____________ MRN: __________________

PATIENT HISTORY Reason you are here for an MRI today? Please explain your medical problem(s) in detail.
If possible, list the problem & the body area(s) experiencing the problem:

____

Date of injury or how long you have had symptoms: ____

Have you had surgery in the area being scanned? **Yes ☐ No ☐** If yes, please specify the type & date: ____________________

Any history of trauma or injury in the area we are scanning today? **Yes ☐ No ☐** If yes, please describe: _________________

Do you have a history of cancer? **Yes ☐ No ☐** If yes, please describe: ____________________________________

Have you had any prior imaging performed related to your current problem or current area of the scan? **Yes ☐ No ☐**

If yes, please specify dates, image type, company: ____

Do you have any food or drug allergies? **Yes ☐ No ☐** If yes, please describe: _______________________________

Have you ever had an anaphylactic reaction to Magnetic Resonance Imaging (MRI) contrast in the past? **Yes ☐ No ☐**

Have you been pre-Medicated for this exam due to an allergic reaction to (MRI) contrast in the past? **Yes ☐ No ☐**

If "Yes" please sign "INFORMED CONSENT --- PREMEDICATED PATIENT" form.

If pre-Medicated: Prescribed Medications: _______________________________ Prescribed by: _____________________

Do you have or have had any history of kidney (renal) insufficiency or failure? **Yes ☐ No ☐** → Are you on dialysis? **Yes ☐ No ☐**

Have you ever had a metal injury to the eye? **Yes ☐ No ☐**

FEMALE ONLY

Is there a possibility that you are pregnant? Yes ☐ No ☐ LMP: _____________ Are you nursing? **Yes ☐ No ☐**

CONSENT FOR CONTRAST ADMINISTRATION

As part of your exam, we may need to inject you with a contrast solution that will highlight the images to provide important diagnostic information. During the injection, you may feel a cool or warm sensation near the injection site or experience a slight metallic taste which will dissipate after the completion of the injection. Although rare, an adverse reaction can occur. In very rare cases this could be severe. Your signature below indicates you consent for Sensible MRI associates to administer intravenous contrast if ordered or recommended by a radiologist.

____
Patient/Guardian/Representative Date

____
Technologist & Credentials Date

____
Date and Time of Administration Time Date

____
Contrast Name Amount Strength

____
Injection Site Lot # & Expiration

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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). 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**. Before entering the MRI environment or MRI 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, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocketknife, nail clipper, tools, clothing with metal fasteners and clothing with metallic threads. Safety risks from Radiofrequency (RF) waves include potential tissue heating and burns. Alert the scanner operator immediately if warming occurs. Please note that some warming is normal, but you should **NEVER** be uncomfortable.

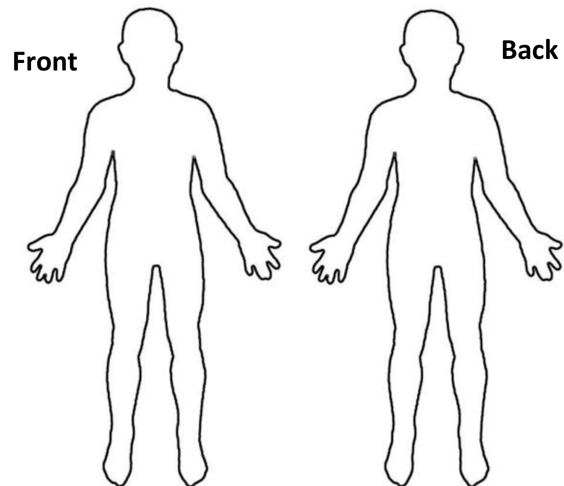
IMPORTANT NOTICE: The noise generated by scanning may reach a level in the scan room and in the bore of the magnet that can result in temporary (and occasionally) permanent hearing loss. Any patient who undergoes an MRI, as well as anyone in Zone 4 during a scan, **MUST** wear hearing protection. Your exam may be monitored for quality assurance.

Please indicate if you have any of the following.

			Make:	Model:	Implant Date:
☐ Yes	No ☐	Aneurysm clip(s)			
☐ Yes	No ☐	Cardiac pacemaker			
☐ Yes	No ☐	Implanted cardioverter defibrillator (ICD)			
☐ Yes	No ☐	Electronic implant or device			
☐ Yes	No ☐	Magnetically activated 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 limb			
☐ 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
☐ 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)
☐ Yes	No ☐	Other implant
☐ Yes	No ☐	Breathing problem or motion disorder
☐ Yes	No ☐	Claustrophobia

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



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 regarding the MRI procedure I am about to undergo.

Signature of person completing form: ____Date: _________________

Form completed by: ☐ Patient ☐ Relative ☐ Nurse/Caregiver Printed Name ____________________________

Technologist ____Date: _____________________