NORTHVIEW OPEN MRI PATIENT SCREENING

PATIENT NAME: _____
DATE OF BIRTH: _____ **AGE**: _____ **WEIGHT**: _____
SYMPTOMS FOR HAVING MRI TODAY: _____

CIRCLE CORRECT ANSWER TO THE FOLLOWING QUESTIONS:

1. YES NO DO YOU HAVE A PACEMAKER?
2. YES NO HAVE YOU EVER HAD METAL FRAGMENTS IN YOUR EYES?
   IF YES, HAVE THEY BEEN REMOVED? YES NO WHEN: _____
3. YES NO HAVE YOU EVER HAD BRAIN SURGERY?
   IF YES, DO YOU HAVE BRAIN CLIPS? YES NO
4. YES NO HAVE YOU HAD RENAL AND/OR KIDNEY DISEASE?
5. YES NO HAVE YOU EVER HAD SURGERY ON YOUR SPINE?

****IF YOU ANSWERD YES TO ANY OF THE QUESTIONS 1-5**
PLEASE NOTIFY THE STAFF BEFORE CONTINUING.**

6. YES NO DO YOU HAVE A HISTORY OF CANCER?
7. YES NO DO YOU HAVE REMOVABLE DENTAL WORK?
8. YES NO DO YOU HAVE ASTHMA?
9. YES NO ARE YOU CLAUSTROPHOBIC?
10. YES NO DO YOU HAVE ANY ALLERGIES?

THE FOLLOWING ITEMS CAN INTERFERE WITH MRI IMAGING AND SOME MAY JEOPARDIZE YOUR SAFTEY, PLEASE INDICATE WITH A CHECK MARK IF YOU HAVE ANY OF THESE ITEMS IN YOUR BODY.

_____ AORTIC CLIPS
_____ CAROTID CLIPS
_____ HEART VALVE REPLACEMENT
_____ SCHRAPNEL/BB'S/BUCKSHOT
_____ INSULIN PUMP OR PORT
_____ INFUSION PUMP (PORTA CATH)
_____ COCHLEAR IMPLANT IN EAR
_____ SHUNT IN BRAIN
_____ PENILE IMPLANT
_____ JOINT REPLACEMENT
_____ BONE OR JOINT PINS
_____ PROSTHESIS
_____ METAL MESH
_____ WIRE SUTURES
_____ HEARING AIDS
_____ ANY OTHER METAL OR FOREIGN BODY, DESCRIBE: _____

YES NO HAVE YOU HAD X-RAYS OF THE AREA WE ARE SCANNING TODAY?
IF YES, WHEN? _____
YES NO HAVE YOU HAD A PREVIOUS MRI OF THE AREA WE ARE SCANNING?
IF YES, WHEN? _____

WOMEN ONLY:

YES NO ARE YOU PREGNANT AT THIS TIME?
YES NO DO YOU HAVE AN IUD?
IF YES, WHAT KIND? _____

THIS PROCEDURE WILL BE EXPLAINED TO YOU BY THE TECHNOLOGIST, AND ALL QUESTIONS ADDRESSED PRIOR TO THE MRI SCAN.

PLEASE READ AND SIGN IF APPLIES:

I DO NOT HAVE A PACEMAKER, NOR HAVE I HAD SURGERY REQUIRING ANEURYSM CLIPS. I DO NOT HAVE COCHLEAR IMPLANTS IN THE EAR, NOR DO I HAVE METALLIC FOREIGN BODIES IN THE EYE. I AM FULLY AWARE THAT IF I HAVE ANY OF THE ABOVE, AN MRI SCAN COULD BE HAZARDOUS TO MY HEALTH. THE ABOVE QUESTIONS HAVE BEEN ANSWERED TRUTHFULLY AND I AGREE TO THE MRI STUDY.

PATIENT'S SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN'S SIGNATURE: _____ **DATE:** _____

TECHNOLOGIST'S SIGNATURE: _____ **DATE:** _____