

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

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: _____