The Alpine Clinic

MRI Screening Form

Name: _____ DOB: _____ Sex: ❑ F ❑M

Phone: _____ Insurance Type: _____ Weight: _____

Ordering Physician: _____ Ordering Physician Phone: _____

Primary Care Physician: _____ Primary Care Physician Phone: _____

Type of Exam: ❑ MRI ❑ MRA Specify Body Part: _____ ❑ Left ❑ Right

Please list symptoms: _____

_____

How long have you had symptoms? _____

❑ Yes ❑ No Was there an injury that caused your symptoms? _____

❑ Yes ❑ No Have you had surgery on the specific body part? Date _____

Attention patients and/or family members: The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body that can interfere with your can or be dangerous to you. So to ensure you safety, PLEASE ANSWER THE FOLLOWING QUESTIONS CAREFULLY:

❑ Yes ❑ No Pacemaker, Wires or Defibrillator
❑ Yes ❑ No Cochlear Implants/ Internal Hearing Aid
❑ Yes ❑ No Brain / Aneurysm Clips
❑ Yes ❑ No Orthopedic Hardware
❑ Yes ❑ No Metal Shrapnel, fragments or bullets
❑ Yes ❑ No Cataract or Eye implant
❑ Yes ❑ No Coil, Filter, or wire in blood vessel
❑ Yes ❑ No Artificial Limb or Joint
❑ Yes ❑ No Tattoos or Tattooed eyeliner
❑ Yes ❑ No Are you Breast feeding?
❑ Yes ❑ No Insulin Pump
❑ Yes ❑ No Artificial Heart Valve
❑ Yes ❑ No Have you had an MRI before?
❑ Yes ❑ No Have you ever been a metal worker?

❑ Yes ❑ No Pregnant or possibly pregnant
❑ Yes ❑ No Non Removable Electronic Device (?Tens)
❑ Yes ❑ No Implants with magnets anywhere
❑ Yes ❑ No Penile Prosthesis
❑ Yes ❑ No Diaphragm or intrauterine device
❑ Yes ❑ No Foil Nitroglycerine or Nicotine patches
❑ Yes ❑ No Silver Wound Dressing
❑ Yes ❑ No Ear or body piercings
❑ Yes ❑ No False teeth, retainers, or magnetic braces
❑ Yes ❑ No Latex Allergy
❑ Yes ❑ No Implanted Catheter, tube or Shunt
❑ Yes ❑ No Do you have Diabetes?
❑ Yes ❑ No Are you Claustrophobic?

❑ Yes ❑ No Have you always worn eye protection when exposed to metal working?

❑ Yes ❑ No Have you ever had an injury in the face or eye with a metallic object? Date_____

❑ Yes ❑ No History of any cancer? Type: _____

❑ Yes ❑ No Have you ever had a colonoscopy? When_____ Where _____

❑ Yes ❑ No Have you had surgery in the past 8 weeks? Date _____ Where _____

Please List all surgical procedures with dates: _____

_____

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the content of t his form. I authorize MRI personnel to access all pertinent medical information necessary to perform this exam.

Signature (parent/Guardian) _____ Date: _____

MUSIC IS AVAILABLE TO LISTEN TO DURING YOUR EXAM. PLEASE FEEL FREE TO BRING A CD OR IPOD IF YOU WOULD LIKE. ☺

Gadolinium Contrast

Important Information: Your examination may require an I.V. injection of a contrast agent called gadolinium. Although gadolinium has been used safely in millions of cases, minor reactions (principally headache or nausea) occur in about 2% of patients, while serious or life-threatening reactions have been reported in about 1 in 400,000 patients. People with a compromised renal system have experienced a very small risk of developing a disease called Nephrogenic system Fibrosis (NSF). To date, NSF has occurred in patients with kidney disease and the vast majority if not all of those have severe or end state renal disease.

- ❑ Yes ❑ No Have you had a previous allergic reaction to X-Ray, CT or MRI contrast material?
- ❑ Yes ❑ No Do you have a history of Asthma?
- ❑ Yes ❑ No Have you had an injection of GADOLINIUM in the past 7 days?
- ❑ Yes ❑ No Are you being treated for kidney disease?
- ❑ Yes ❑ No Are you currently undergoing dialysis?
- ❑ Yes ❑ No Do you have a history of Hypertension?

Signature: _____ Date:_____