

mri screening form

locations

Lisle Glen Ellyn Lombard Naperville (Rickert)

Scheduler's initials _____

Exam date _____

Last name _____ First name _____ GE# _____

Date of birth _____ Height _____ Weight _____

Who is your ordering physician? _____

Yes No Have you had any previous tests for the body part on which we are doing the scan today?

MRI	Date _____	Facility location _____
CT/CAT scan	Date _____	Facility location _____
Xray	Date _____	Facility location _____
Ultrasound	Date _____	Facility location _____
Nuclear medicine	Date _____	Facility location _____

Please review the following answers you provided when scheduling your test.

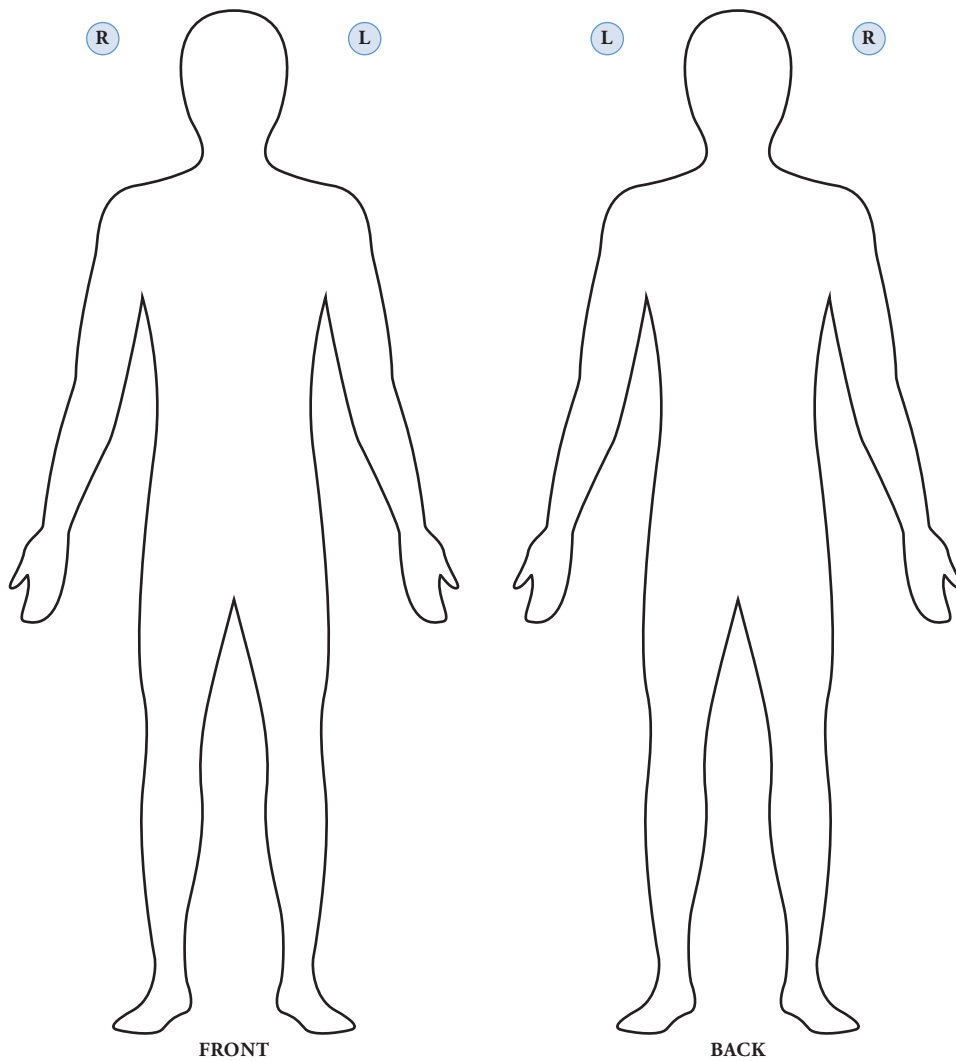
<input type="checkbox"/> Yes <input type="checkbox"/> No Claustrophobia	<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma
<input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac pacemaker, pacing wires or defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No Life threatening contrast allergies
<input type="checkbox"/> Yes <input type="checkbox"/> No Carotid artery, vascular clip/clamp (aortic etc)	Type of reaction _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Aneurysm clip(s) or shunt	<input type="checkbox"/> Yes <input type="checkbox"/> No Latex or adhesive allergy
<input type="checkbox"/> Yes <input type="checkbox"/> No Neurostimulator/biostimulator or implanted pumps (i.e. insulin, infusion, stimulators, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetic
Manufacturer _____ Model# _____	If yes, do you take insulin and/or oral medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No Any type of prosthesis (eye, ear, penile, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No History of kidney disease, kidney failure or renal dialysis
Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Ear or body piercings
<input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Limb(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No Tattooed makeup (eyeliner, lips, etc.)
<input type="checkbox"/> Yes <input type="checkbox"/> No Implants, stents or artificial valves	<input type="checkbox"/> Yes <input type="checkbox"/> No Vascular access port and/or catheter
Type _____ When _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Bone/joint pin, screw, nail, wire, plate
Manufacturer _____ Model _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Dental implants (within 6 weeks)
<input type="checkbox"/> Yes <input type="checkbox"/> No IUD or Diaphragm	<input type="checkbox"/> Yes <input type="checkbox"/> No If female, chance of pregnancy
<input type="checkbox"/> Yes <input type="checkbox"/> No Shrapnel or bullets	<input type="checkbox"/> Yes <input type="checkbox"/> No LMP _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Metallic injury to the eye	<input type="checkbox"/> Yes <input type="checkbox"/> No If female, are you nursing
Was it removed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Medical/surgical history _____

Cancer history _____

Yes No Do you have anemia, any diseases that affect your blood or a history of renal disease or seizures? (please describe below)

Describe your current pain and/or symptoms



Please indicate on the drawing where the pain is located. Be as specific as possible.

I verify that this information is correct to the best of my knowledge.

Signature of Patient _____ Date _____

Form completed by: (please circle one) Patient Relative Other

Name and relationship to patient _____

Note: You are required to wear earplugs or earphones during the MRI Examination

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination.

Before your MRI, please remove all metallic objects including hearing aids, keys, hair pins, barrettes, jewelry, body piercings, watches, safety pints, paper clips, money clips, credit cards, coins, pens, belts, metal buttons, pocket knives, and clothing with metal in the material.