Salem Health® Hospitals & Clinics

Magnetic Resonance Imaging (MRI) Screening Form

Date: ______________

Last Name: ____________________________________ First Name: ____________________ Middle Initial: _____

Age: _____ Height: ______ Weight: _____ Date of Birth (MM/DD/YY): ______________ ☐ Male ☐ Female ☐ Other

Body part to be examined: ____

Reason for MRI and/or symptoms:

____

____

____

Have you had prior surgery or an operation **on this body part** of any kind? ☐ Yes ☐ No

If yes, please indicate the date and type of surgery:

Date: _______________ Type of Surgery: ____

Date: _______________ Type of Surgery: ____

Have you had a prior diagnostic imaging study (MRI, CT, Ultrasound, X-Ray, etc.) on this body part?

☐ Yes ☐ No

If yes, please list:

☐ MRI	Body Part: _____________	Date: ________	Facility: ________________________________
☐ CT/CAT Scan	Body Part: _____________	Date: ________	Facility: ________________________________
☐ X-Ray	Body Part: _____________	Date: ________	Facility: ________________________________
☐ Ultrasound	Body Part: _____________	Date: ________	Facility: ________________________________
☐ Nuclear Medicine	Body Part: _____________	Date: ________	Facility: ________________________________
☐ Other	Body Part: _____________	Date: ________	Facility: ________________________________

Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ Yes ☐ No

If yes, please describe: ____

Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)?

☐ Yes ☐ No

If yes, please describe: ____

Are you allergic to any medication? ☐ Yes ☐ No

If yes, please list:

____

____

Do you have a history of asthma, allergic reaction, respiratory disease or reaction to a contrast medium used for MRI?

☐ Yes ☐ No

For female patients: Are you pregnant or suspect that you might be pregnant? ☐ Yes ☐ No

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MR procedure (i.e. MRI, MR angiography, functional MRI, MR spectroscopy). 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.

Please indicate if you have any of the following:

☐ 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/device
☐ Yes ☐ No Neurostimulation system
☐ Yes ☐ No Metallic stent, filter or coil
☐ Yes ☐ No Shunt (spinal or intraventricular)
☐ 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 pump, CGM or infusion device
☐ 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 Vascular access port and/or catheter
☐ Yes ☐ No Radiation seeds or implants
☐ Yes ☐ No Swan-Ganz or thermodilution catheter
☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
☐ 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 system room)
☐ Yes ☐ No Other implant ______________________
☐ Yes ☐ No Breathing problem or motion disorder
☐ Yes ☐ No Claustrophobia

IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plate, keys, cell phone, eyglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, and clothing with metallic threads. Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE** you enter the MR system room.

Note: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

I authorize the release of any medical information, including prior xrays, to be released to Salem Health Hospitals and Clinics to be used in the continuum of my medical care:

Patient Signature: ____ Date: ____________________

If patient is a minor, the parent/guardian: ________________________________ Date: ____________________

OFFICE USE:
Form information reviewed by: __________________________________ Date: ________________________