

Beaumont

Name: _____	Date: _____	
DOB: _____	Height: _____	Weight: _____

MRI Patient Information Form- validate information by review of medical record if available

List operations or surgeries: _____

Have you had a previous reaction to CT/MRI contrast? No Yes

If yes, explain: _____

Are you claustrophobic? No Yes

BODY/PROSTATE

In an effort to provide you with the best care possible, please complete the following questions to the best of your ability.

Why did your doctor request this prostate MRI _____

Have you recently been treated for a urinary tract infection or prostatitis? No Yes

What is your PSA (blood test) level? _____

Do you have a history of prostate cancer? No Yes

Have you been treated for prostate cancer? No Yes

If yes, what type of treatment and when? _____

Have you had a prostate biopsy? No Yes If yes, when _____

What was the result of your biopsy? _____

What is your Gleason score? _____

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MRI Safety Screening Form

Brain aneurysm clip	<input type="checkbox"/> No <input type="checkbox"/> Yes	Orthopedic Implants	<input type="checkbox"/> No <input type="checkbox"/> Yes
Breast tissue expander	<input type="checkbox"/> No <input type="checkbox"/> Yes	Pacemaker Wires/Leads	<input type="checkbox"/> No <input type="checkbox"/> Yes
Bullets, Shrapnel	<input type="checkbox"/> No <input type="checkbox"/> Yes	Pain/Bladder Stimulator	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cardiac Defibrillator (ICD)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Piercings (must remove)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cardiac Pacemaker	<input type="checkbox"/> No <input type="checkbox"/> Yes	Programmable Shunt	<input type="checkbox"/> No <input type="checkbox"/> Yes
Color Contacts (must remove)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Prosthesis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eye or Ear Implant (cochlear)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sleep Therapy Generator	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hearing Aid (must remove)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Shunt (brain or spinal)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Valve Prosthesis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stents (carotid, heart, renal)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Infusion Pump (ex: Pain/Insulin)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Surgical Clips or Staples	<input type="checkbox"/> No <input type="checkbox"/> Yes
Continuous Glucose Monitor	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tattoo/Tattoo Make-up	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have an IUD?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Vascular Access Port	<input type="checkbox"/> No <input type="checkbox"/> Yes
Medication Patch (must remove)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Vascular Filter, Coil, Clamp	<input type="checkbox"/> No <input type="checkbox"/> Yes
Metal Fragments (eye, skin)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Any other implants	<input type="checkbox"/> No <input type="checkbox"/> Yes

List any possible metallic injury, foreign body, metal shavings _____

Please inform your technologist if you have had a Capsule Endoscopy (swallowed a pill camera).

If yes to any questions please explain. _____

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE PROVIDED IS CORRECT.

Patient Signature _____ Date: _____

MRI STAFF

Patient Approved for MRI Scan? No Yes

MRI Technologist Signature _____ Date: _____ Time: _____

SITE _____ PHONE # _____

Order/Rx verification

- Part
- Right Left Bilateral
- Checked 2 Identifiers

CONTRAST

- Dotarem Eovist
- Gadovist Multihance
- Prohance
- Amount given _____
- FDA medication guide reviewed by patient

Technologist Notes _____
