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

For Female Patients:

Are you pregnant now or could you possibly be pregnant? ☐ No ☐ Yes

If YES, does your doctor know that you are pregnant? ☐ No ☐ Yes

Are you breastfeeding? ☐ No ☐ Yes

BREAST

☐ Lump/tenderness ☐ right ☐ left

☐ Discharge ☐ right ☐ left

☐ Cancer ☐ right ☐ left

☐ Chemotherapy Date: __________

☐ Radiation Date: __________

☐ Family history ☐ No ☐ Yes

Relationship: __________

Breast surgeries (biopsy, lumpectomy, reduction)

Type: __________

☐ Birth control/hormone use history

Have you used hormones/estrogen ☐ No ☐ Yes

When __________

When was last menstrual period __________

Note: Imaging should be performed between day 5-15 of last menstrual period.

When: __________

7000 110318 OS8

Beaumont

MRI Safety Screening Form

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

____

____