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

NEURO/BRAIN

What is your current problem? _____

How long have you had this problem? _____

Have you had surgery on the area of interest? ☐ No ☐ Yes When _____

Do you have a history of cancer? ☐ No ☐ Yes If yes, when and what kind _____

Do you have or had any of the following? (Check all that apply)

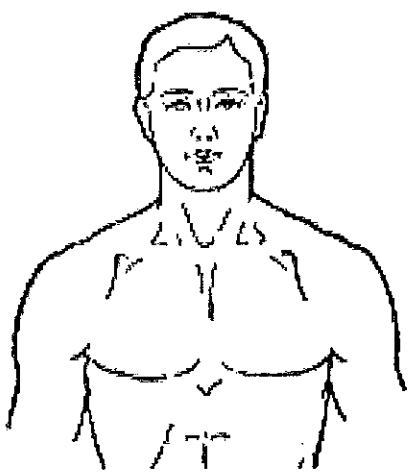
☐ behavior/memory change ☐ dizziness ☐ headaches ☐ hearing change ☐ injury

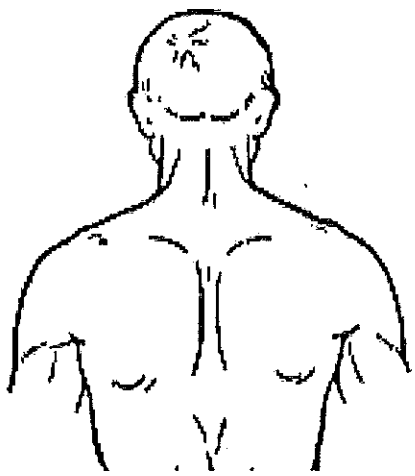
☐ nausea ☐ numbness ☐ pain ☐ seizure ☐ sense of falling ☐ stroke

☐ syncope ☐ visual change ☐ vomiting ☐ weakness ☐ other

Any previous imaging? ☐ X-rays ☐ CT ☐ MRI If yes where and when _____

USING THE FIGURES BELOW, PLEASE SHADE IN THE AREAS AFFECTED BY PAIN, MASS, OR INJURY





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MRI Safety Screening Form

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

_____

_____