

# 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/SOFT TISSUE NECK

What is your current problem? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Have you had surgery on the area of interest?  No  Yes When \_\_\_\_\_

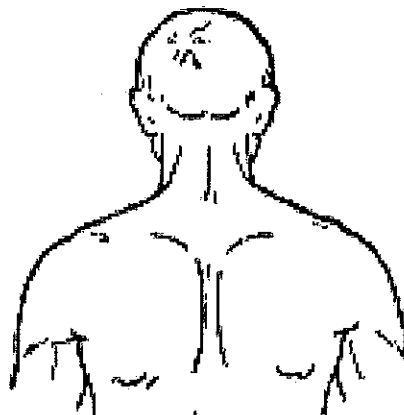
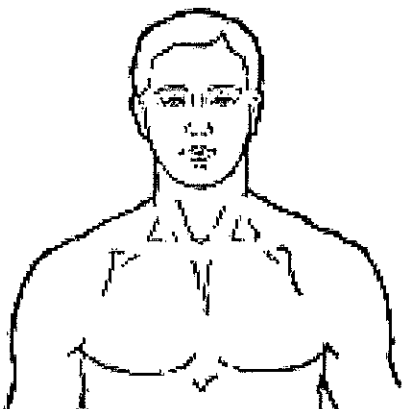
Do you have a history of cancer?  No  Yes If yes, when and what kind \_\_\_\_\_

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

- |   |   |  |                                    |   |
|---|---|--|------------------------------------|---|
| <input type="checkbox"/> buzzing in ears  | <input type="checkbox"/> dizziness        | <input type="checkbox"/> facial pain           | <input type="checkbox"/> headaches | <input type="checkbox"/> hearing change |
| <input type="checkbox"/> infection        | <input type="checkbox"/> loss of appetite | <input type="checkbox"/> lump/mass             | <input type="checkbox"/> nosebleed | <input type="checkbox"/> pain           |
| <input type="checkbox"/> sinus congestion | <input type="checkbox"/> smoker           | <input type="checkbox"/> swallowing difficulty | <input type="checkbox"/> swelling  | <input type="checkbox"/> weight loss    |

Any previous imaging?  X-rays  CT  Ultrasound  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	<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 \_\_\_\_\_