

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

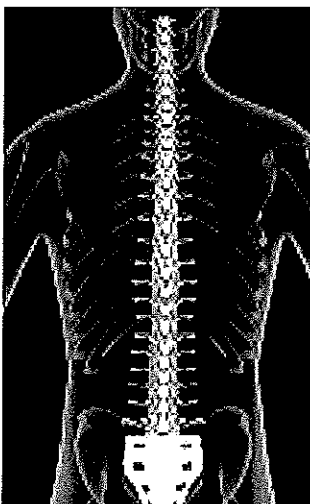
Are you breastfeeding? No Yes

NEURO/SPINE

What is your current problem? _____
How long have you had this problem? _____
Have you had spinal surgery? If yes, when and what area of spine _____
Do you have a history of cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when and what kind _____

Do you have any of the following? (Check all that apply)	Weakness and tingling in extremities?
<input type="checkbox"/> dizziness <input type="checkbox"/> headaches <input type="checkbox"/> injury <input type="checkbox"/> mass	<input type="checkbox"/> upper <input type="checkbox"/> right <input type="checkbox"/> left
<input type="checkbox"/> nausea <input type="checkbox"/> numbness <input type="checkbox"/> pain <input type="checkbox"/> stroke	<input type="checkbox"/> lower <input type="checkbox"/> right <input type="checkbox"/> left
Any previous imaging? <input type="checkbox"/> X-rays <input type="checkbox"/> CT <input type="checkbox"/> MRI If yes where and when _____	

USING THE FIGURES BELOW, PLEASE SHADE IN THE AREAS AFFECTED BY PAIN AND/OR NUMBNESS



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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 _____
