MDR METAL SCREENING

FORM PATIENT NAME:_____

Warning: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI Procedure. Do not enter the MR system room or MR Environment if you have any question or concern regarding an implant ,device or object. Inform the MRI Technologist before entering the MRI system room. The MRI Scanner is ALWAYS ON!

PRE CONTRAST SCREENING QUESTIONS

YES NO

- ☐ ☐ Have you ever experienced a severe allergic reaction to anything ?
- ☐ ☐ If you have any allergies? List the allergy and what happens to you. 1)_____ 2)_____ 3_____ 4)_____
- ☐ ☐ Have you ever had a reaction to a contrast medium used for MRI or CT?
- ☐ ☐ Are you allergic to benzyl alcohol ? (No Multihance)
- ☐ ☐ Do you have a history of asthma, allergic respiratory disease or seizures ?
- ☐ ☐ Have you had a recent vascular surgery? Including kidney or liver transplantation, arteriovenous graft revision or an acute venous thrombosis?
- ☐ ☐ Are you pregnant or do you suspect that you are pregnant?

YES NO

- ☐ ☐ Do you have diabetes?
- ☐ ☐ Have you been told you have kidney disease?
- ☐ ☐ Do you have liver disease?

YES NO

- ☐ ☐ Do you have high blood pressure?
- ☐ ☐ Do you receive kidney dialysis?
- ☐ ☐ Are you breast feeding?

The following items may be harmful to you during your MR scan or may interfere with the MR examination. You must provide a "yes" or "no" for every item. Please indicate if you have any of the following:

YES NO

- ☐ ☐ Have you had a surgery or procedure in your lifetime, Please list below and give the date of the surgery.
  1)_____ 2)_____ 3)_____
  4)_____ 5)_____ 6)_____
- ☐ ☐ Ever had an eye injury with metallic slivers or shavings
- ☐ ☐ Cardiac pacemaker or ever have a temporary one
- ☐ ☐ Aneurysm clip
- ☐ ☐ Implanted cardiac defibrillator
- ☐ ☐ Internal electrodes or retained pacemaker wires
- ☐ ☐ Artificial heart valve or heart prosthesis
- ☐ ☐ Neurostimulator or biostimulator (e.g. spinal,bladder etc.)
- ☐ ☐ Any electronic, mechanical or magnetic implants
- ☐ ☐ Stent, coil or filter type:_____
- ☐ ☐ Cochlear implant
- ☐ ☐ Any type of ear implant (otologic implant)
- ☐ ☐ Hearing aid (please remove or aid can be damaged)
- ☐ ☐ Any artificial prosthesis (eye,penile,heart etc.)
- ☐ ☐ Swan ganz catheter or thermodialtion catheter
- ☐ ☐ Any I.V. access port (port-a-cath,hickman,picc line)
- ☐ ☐ Shunt (Spinal or Ventricular)
- ☐ ☐ Do you have any type of drug infusion device
- ☐ ☐ Surgical clips or staples
- ☐ ☐ Skin staples
- ☐ ☐ Ever been injured by any metallic foreign body (Bullet,shrapnel, etc.)
- ☐ ☐ Artificial limb or joint
- ☐ ☐ Any implanted items (pins,rods,screws,nails,plates,wires)
- ☐ ☐ Surgical or wire mesh location:_____
- ☐ ☐ Eyelid springs, weights or wires
- ☐ ☐ Diaphragm, iud or pessary type:_____
- ☐ ☐ Tissue expander (Breast)
- ☐ ☐ Tattoo's: Where is it located _____
- ☐ ☐ Permanent makeup (tattooed eyeliner)
- ☐ ☐ Jewelry or body piercings location:_____
- ☐ ☐ Radiation seeds or implants
- ☐ ☐ Medications patches (All patches should be removed)
- ☐ ☐ Wigs,hairpieces,hair implants, bobby pins, barrettes ?
- ☐ ☐ Wound dressings impregnated with silver
- ☐ ☐ Dentures, partial plates or false teeth
- ☐ ☐ Any type of implanted item not listed type:_____
- ☐ ☐ Do you have a health care proxy? If you do please send MDR a copy as soon as possible.
  Who is your health proxy?_____

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.
Patient Signature:_____ Date:_____ Your Weight:_____

If the patient is incapable of completing this form or is a minor (under 18 years of age), please document the persons name completing this form and their relationship to the patient.

Name:_____ Signature:_____ Relationship to patient:_____

HOSPITAL STAFF THAT COMPLETED SCREENING FORM WITH PATIENT PHONE NUMBER:_____
The Above information has been reviewed and approved by me (MD / PA / NP / RN) prior to exam.

Name:_____Signature:_____Title:_____Date:_____ Time:_____

For Technologist Use Only ☐ Squeeze ball ☐ Earplugs ☐ Music ☐ TV ☐ Claustrophobic

Technologist Signature:_____ revised 5/7/13