KENAI PENINSULA ORTHOPAEDICS

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date: ____/___/____ Account Number: _____

Name: _____ Age: _____ Height:_____ Weight:_____
Last name First Name Middle Initial

Date of Birth:____/___/____ Male Female Body Part to be Examined_____

Address:_____ Telephone (home) (___) ____-_____
City: _____ Telephone (work) (___)____-_____
State:_____ Zip Code:_____

Reason for MRI and/or Symptoms:_____

Referring Physician:_____ Telephone: (___)____-_____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?
YES OR NO
If yes, please indicate the date and type of surgery:
Date: ___/___/____ Type of Surgery:_____
Date:___/___/____ Type of Surgery:_____

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-Ray, etc.)?
YES OR NO

If yes, please list:	Body Part	Date	Facility
MRI	_____	_____/_____/____	_____
CT/Cat Scan	_____	_____/_____/____	_____
X-Ray	_____	_____/_____/_____	_____
Ultrasound	_____	_____/_____/____	_____
Nuclear Medication	_____	_____/_____/_____	_____

3. Have you experienced any problem relating to a previous MRI examination or MR procedure? **YES OR NO**
If yes, please describe: _____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g.,) metallic slivers, shavings, foreign body, etc.)? **YES OR NO**
If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign (e.g., BB, bullet, shrapnel, etc.)? **YES OR NO**
If yes, please describe:_____

6. Are you currently taking or have you recently taken any new medication or drug? **YES OR NO**
If yes, please list:
_____

7. Are you allergic to any medication? **YES OR NO**
If yes, please list: _____

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, X-Ray examination? **YES OR NO**

9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures?
If yes, please describe: _____

For female patients:
10. Date of last menstrual period: ____/____/_____ **Post-menopausal? YES OR NO**

11. Are you pregnant or experiencing a late menstrual period? **YES OR NO**

12. Are you taking oral contraceptives or receiving hormonal treatment? **YES OR NO**

13. Are you taking any type or fertility medication or having fertility treatments? **YES OR NO**
If yes, please describe: _____

14. Are you currently breastfeeding? **YES OR NO**

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. The MR system magnet is **ALWAYS** on.

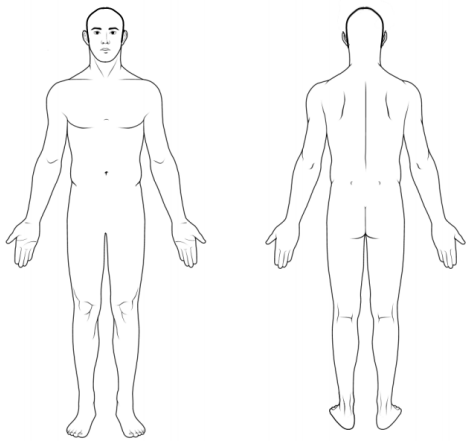
Please indicate if you have any of the following:

YES **NO** Aneurysm clip(s)
YES **NO** Cardiac pacemaker
YES **NO** Implanted cardioverter defibrillator (ICD)
YES **NO** Electronic implant or device
YES **NO** Magnetically-activated implant or device
YES **NO** Neurostimulation system
YES **NO** Spinal cord stimulator
YES **NO** Internal electrodes or wires
YES **NO** Bone growth/bone fusion stimulator
YES **NO** Cochlear, otologic, or other ear implant
YES **NO** Insulin or other infusion pump
YES **NO** Implanted drug infusion device
YES **NO** Any type of prosthesis (eye, penile, etc.)
YES **NO** Heart valve prosthesis
YES **NO** Eyelid spring or wire
YES **NO** Artificial or prosthetic limb
YES **NO** Metallic stent, filter, or coil
YES **NO** Shunt (spinal or intraventricular)
YES **NO** Vascular access port and/or catheter
YES **NO** Radiation seeds or implants
YES **NO** Swan-Ganz or thermodilution catheter
YES **NO** Medication patch (Nicotine, Nitroglycerine)
YES **NO** Any metallic fragment or foreign body
YES **NO** Wire mesh implant
YES **NO** Tissue expander (e.g., breast)
YES **NO** Surgical staples, clips, or metallic sutures
YES **NO** Joint replacement (hip, knee, etc.)
YES **NO** Bone/Joint pin, screw, nail, wire, plate, etc.
YES **NO** IUD, diaphragm, or pessary
YES **NO** Dentures or partial plates
YES **NO** Tattoo or permanent makeup
YES **NO** Body piercing jewelry
YES **NO** Hearing aid *(Remove before entering MR system room)*
YES **NO** Other implant _____
YES **NO** Breathing problem or motion disorder
YES **NO** Claustrophobia

IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove **all** metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any questions or concern BEFORE you enter the MR system room.



Please mark on the figure(s) the location of any implant or metal inside of or on your body.

<u>NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure o prevent possible problems or hazards related to acoustic noise.</u>

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date: ___/___/_____
Signature

Form Completed By: [ ] Patient [ ] Relative [ ] Nurse _____ _____
Print Name *Relationship to Patient*

Form Information Reviewed by: _____ _____
Print Name *Signature*

[ ] MRI Technologist [ ] Nurse [ ] Radiologist [ ] Other _____