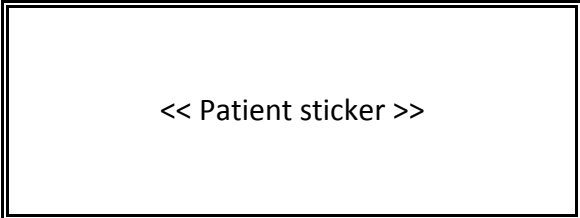


Outpatient MRI Screening Form

The following items may interfere with MR imaging and some may be hazardous to your safety



Please check YES or No for the following:

YES NO

- ANEURYSM CLIPS FROM BRAIN SURGERY
- CARDIAC PACEMAKER / AUTOMATIC DEFIBRILATOR
- NEUROSTIMULATOR (for pain control) or DEEP BRAIN STIMULATOR (for Tremors)
- INDWELLING DEVICE OR CATHETER FOR PAIN MANAGEMENT
- PROGRAMABLE VP SHUNT (if yes, we will need to verify valve status before & after the MRI)
If you experience any clinical changes after the MRI, please notify your referring physician immediately.
- HEARING AID, COCHLEAR IMPLANT, OR STAPES PROSTHESIS
- SHRAPNEL FROM WARTIME ACTIVITY, BB OR BULLET FRAGMENT FROM A GUNSHOT WOUND
- HAVE YOU HAD AN INJURY TO THE EYE INVOLVING A METALLIC OBJECT OR FRAGMENT,
Even if it was removed. ex: Metallic slivers, shavings, foreign body, Etc.
- VENOUS UMBRELLA OR FILTER TO CORRECT A BLOOD CLOT CONDITION
- STENTS (location & date): _____
- INSULIN PUMP
- TRANSDERMAL PATCH FOR NICOTINE OR OTHER MEDICATIONS
- REMOVABLE DENTURES OR OTHER REMOVABLE DENTAL APPLIANCES
- TISSUE EXPANDER FOR BREAST RECONSTRUCTION
- OTHER METAL IMPLANTS (PLEASE EXPLAIN): _____
- TATTOO
- ARE YOU PREGNANT or NURSING
- ANY LATEX ALLERGY?
- ARE YOU ON DIALYSIS
- DO YOU HAVE A CANCER HISTORY: _____
- SURGERIES (PLEASE EXPLAIN): _____

Today's Date: / /

Start date of last menstrual period: / /

Signature of patient: _____

Signature of parent or guardian: _____

Date of Birth: / /

Height: _____

Weight: _____

MRI Staff Only

Patient ID Verification - 2 out of 5 Minimum

| | | | | |
|--|--|--|---|---|
| Full name stated by Patient or Family Member | DOB stated by Patient or Family Member | Picture ID verifies full name and DOB against new or existing VM records | Armband marked As verified By VM staff Member | DOB and MRN on Armband matched order and/or existing medical record |
|--|--|--|---|---|

Screening confirmed with patient - Tech Initials: _____

| | | | | |
|--------------|-----------|-------------|-------------------|------------|
| Creat. _____ | GFR _____ | Date: _____ | IV Size/Loc _____ | Tech _____ |
|--------------|-----------|-------------|-------------------|------------|