

MAGNETIC RESONANCE IMAGING CHECKLIST

Please answer **ALL** questions. It is very important to your health to determine your eligibility for magnetic resonance imaging.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____

Phone (home): _____ Phone (work): _____

Weight: _____ Ordering Doctor: _____

Chief complaint: _____

PATIENT HISTORY (ANSWER ALL QUESTIONS) CIRCLE ONE

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Are you pregnant or might you be pregnant? | Yes | No |
| 2. Do you have a heart pacemaker or metal heart valve? | Yes | No |
| 3. Do you have any of the following? | | |
| aneurysm of vascular clips | Yes | No |
| intra-cranial by-pass clips | Yes | No |
| middle ear prosthesis (cochlear implants) | Yes | No |
| orbital prosthesis (false eye) | Yes | No |
| neurostimulator (tens unit) | Yes | No |
| vena cava filter (umbrella) | Yes | No |
| shrapnel, metallic splinters, or other foreign bodies | Yes | No |
| cardiac arrhythmia (irregular heart beat) | Yes | No |
| biostimulator | Yes | No |
| permanent eyeliner, wig, or hairpiece | Yes | No |
| surgical prosthesis (joint replacement) | Yes | No |
| infusion pump (insulin or other medication) | Yes | No |
| any history of gun shot wound | Yes | No |
| metal implants | Yes | No |
| 4. Have you ever been employed as a welder, autobody or metal shop or worked with metal as a hobby, where contact with metallic shavings was possible or likely? | Yes | No |

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|----------------------------------------------------------------------------------------------------------------------|-----|----|
| 5. Have you had previous MRI scans?
Where ? _____ | Yes | No |
| Previous CT scans?
Where ? _____ | Yes | No |
| 6. Have you had previous surgery in the area to be scanned?
If so, please give dates of surgeries: _____
_____ | Yes | No |
| 7. Have you ever had cancer?
If so, what type and when was it discovered? _____
_____ | Yes | No |
| 8. Have you ever had radiation therapy or chemotherapy?
If so, when was your last treatment? _____ | Yes | No |

You may not enter the scan room with any of the following objects:

stimulator - infusion pump - pacemaker - hairpins - contact lenses - barrettes - hearing aid
safety pins - dentures - jewelry - pocket knife - belt - glasses - wallet - keys - credit cards
ink pens - beepers - weapons - watch

The above items as well as other metal items may not be taken into the magnet scan room. They may result in damage to the equipment, MRI system and personal injury to the patient.

I have read and fully understand this questionnaire.

Signature _____

Please Do Not Write Below This Line

After reviewing the above questionnaire it may be necessary to perform x-rays of you to determine if you may undergo the MRI exam. A technologist or radiologist will speak with you if this is necessary. At that time you may decline the x-rays if you wish and your signature below indicates such.

I _____ voluntarily decline x-rays prior to MRI examination to check for foreign bodies. The danger of declining these exams have been explained to me by the technologist or radiologist.

Patient signature _____

Technologist or Radiologist signature _____