

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION

DATE

MRI SCREENING

You have been scheduled for an MRI exam. The MRI scanner uses extremely strong magnetic fields that can produce heating, movement, or electric currents in **ANY metal** in or on your body. **WARNING:** This can be hazardous to you, if you have certain metal objects in or on you. Please complete this accurately and carefully.
 (Please circle **Yes/No** responses)

1. Do you have any metal or possibly metal containing objects in or on your body?

Yes

No

If **yes**, check box and give details _____

- | | |
|---|---|
| <input type="checkbox"/> Aneurysm clip | <input type="checkbox"/> Shunt (programmable) <input type="checkbox"/> non-programmable |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Feeding tube with mercury tip |
| <input type="checkbox"/> Implanted cardioverter defibrillator (ICD) | <input type="checkbox"/> Radiation seeds or implants |
| <input type="checkbox"/> Electronic implant or device | <input type="checkbox"/> Medication patch |
| <input type="checkbox"/> Magnetic stent, filter, or coil | <input type="checkbox"/> Any metallic fragment or foreign body |
| <input type="checkbox"/> Neurostimulator, deep brain stimulator | <input type="checkbox"/> Breast tissue expander |
| <input type="checkbox"/> Spinal cord stimulator | <input type="checkbox"/> Surgical staples, clips |
| <input type="checkbox"/> Internal electrodes or wires | <input type="checkbox"/> Bone/joint pin, screw, nail, wire, plate |
| <input type="checkbox"/> Bone growth/bone fusion stimulator | <input type="checkbox"/> IUD, diaphragm, or pessary |
| <input type="checkbox"/> Cochlear, otologic, or other ear implant | <input type="checkbox"/> Dentures, partial plates, or braces |
| <input type="checkbox"/> Insulin or other infusion pump | <input type="checkbox"/> Permanent makeup or eyeliner |
| <input type="checkbox"/> Implanted drug infusion device | <input type="checkbox"/> Body piercing jewelry |
| <input type="checkbox"/> Prosthesis of any kind(eye, penile, etc.) | <input type="checkbox"/> Eye lid spring or wire |
| <input type="checkbox"/> Heart valve prosthesis | <input type="checkbox"/> Temperature probe |
| <input type="checkbox"/> Artificial or prosthetic limb | <input type="checkbox"/> Hearing aid (remove prior to entry) |

Yes

No

2. Have you had an injury to the eye involving a metallic object or fragment?

Yes

No

3. Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel)?

Yes

No

4. List any past surgeries/Date: _____

Height _____ Weight _____

To be completed for patients who may receive MRI CONTRAST (GADOLINIUM)

5. Have you ever had a previous reaction with intravenous contrast ("x-ray dye")?

Yes

No

If **yes**, give details: _____

6. Have you ever had a life-threatening allergic reaction?

Yes

No

If **yes**, give details: _____

7. Are you 60 years of age or older?

Yes No

8. Do you take medication for diabetes?

Yes No

9. Do you take medication for high blood pressure?

Yes No

10. Do you suffer from kidney disease?

Yes No

11. Does anyone in your family suffer from kidney disease?

Yes No

12. Do you have only one kidney or a kidney transplant?

Yes No

13. Do you have any other organ transplant?

Yes No

14. Do you have multiple myeloma?

Yes No

15. Do you have end-stage liver disease/need a liver transplant?

Yes No

eGFR (To be completed by RN or technologist)

"Yes" answers to Q7-15, enter eGFR within 6 weeks.

"No" answers: if eGFR is available, enter it below.

Level: _____ (mL/min/1.73mL²)

Date: ____/____/____*

< 60

≥ 60
or not
needed

16. **FOR WOMEN:** Is there any possibility that you may be pregnant?

Yes

No

Yes

No

Please sign below to confirm that you have received, read, and understood the "Frequently Asked Questions about MRI exams". A physician is available to answer any further questions you may have.

Form completed by: _____

Signature of Patient/parent/guardian: _____

Signature of RN or Technologist: _____

Date: _____ Time: _____



Consult with Radiologist



Proceed per protocol

INSTRUCTIONS FOR RADIOLOGY RN OR RT

YES answers to questions 7-16 and no recent eGFR available:

Proceed with an immediate Cr/eGFR test at the direction of the protocoling physician.

STOP - If there are ANY circles in the STOP column, further consultation with a supervising radiologist is required before administration of contrast. Nursing and technical staff should consult with a supervising radiologist for further instructions. Proceed only when the order for this examination has been reviewed, and is updated by the supervising radiologist in ImageCast.

GO - If ALL the circled responses are in the GO column: PROCEED with contrast administration as per the contingent order in ImageCast. This order is now final, and the electronic signature of the protocoling physician in conjunction with this form attests that the administration of contrast material has been reconciled with the patient's current medication.



IMPORTANT INSTRUCTIONS

Before entering the MRI environment or MRI 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, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners and clothing with metallic threads.

Please consult the staff if you have any questions or concerns BEFORE you enter the MRI system room.

Filled out by staff:

1. Patient Screened for MRI contraindications? Yes No
2. Patient and Table Top Checked? Yes No
3. Staff Physicians Safety Trained? Yes No
4. Staff/Physicians Removed Metallic Objects? Yes No
5. Final verification/ "time-out" is performed by Yes No

the team prior to entry into the magnet, including patient screening form, and all equipment checked for MRI safety or compatibility.