Patient Label

# WAYNE MRI
## PATIENT SCREENING FORM

**PROCEDURE REQUESTED:** _____ **REQUESTING PHYSICIAN:** _____

**MEDICAL HISTORY:**

List physical symptoms and duration: _____

_____

**Height:____ft.____in. Weight:_____lbs. Allergies:**_____

| | | | | | |
|---|---|---|---|---|---|
| **Possibility of Pregnancy:** | Yes □ | No □ | | | |
| **Asthma:** | Yes □ | No □ | **Personal History of Cancer:** | Yes □ | No □ |
| **Hay fever:** | Yes □ | No □ | **Gastric Bypass Surgery:** | Yes □ | No □ |
| **Sickle Cell:** | Yes □ | No □ | **Currently breastfeeding:** | Yes □ | No □ |
| **Multiple Sclerosis:** | Yes □ | No □ | **Dialysis:** | Yes □ | No □ |

**HAVE YOU EVER BEEN TOLD TO NOT HAVE AN MRI? YES _____ NO _____**

**Please list ALL surgeries you have had since birth:** _____

_____

_____

Have you ever worked in a machine shop or similar environment where you may have been subjected to small metal pieces? Yes □ No □

Have you ever been injured by anything metal that was not removed? Yes □ No □

**THE FOLLOWING ITEMS CAN INTERFERE WITH MRI IMAGING AND SOME CAN ACTUALLY BE HAZARDOUS TO YOUR SAFETY. PLEASE CHECK IF YOU HAVE ANY OF THESE ITEMS:**
**(PLEASE CHECK YES OR NO)**

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| □ | □ | Cardiac Pacemaker | □ | □ | Joint replacement | □ | □ | Metal mesh |
| □ | □ | Defibrillator | □ | □ | Metal plates, pins, or screws | □ | □ | Tinted contacts |
| □ | □ | Brain clips | | | | □ | □ | Tattooed eyeliner |
| □ | □ | Carotid clips (Poppen-Blaylock carotid vascular clamp) | □ | □ | Dentures/Braces | □ | □ | Breast expanders for breast reconstruction |
| | | | □ | □ | Shunts | □ | □ | Bladder stimulator |
| □ | □ | Abdominal clips | □ | □ | Eye implants | **Others:** _____ | | |
| □ | □ | Aortic clips | □ | □ | Wire sutures | | | |
| □ | □ | Neurostimulators (TENS unit) | □ | □ | Shrapnel, shotgun pellets, bullets | _____ | | |
| | | | □ | □ | Penile prosthesis | Have you recently had a small bowel study in which you swallowed a camera capsule? Yes □ No □ | | |
| □ | □ | Vagus nerve stimulator | □ | □ | Harrington rod | | | |
| □ | □ | Heart valve or heart stent | □ | □ | Any type of pain patch | | | |
| | | | □ | □ | Nicotine patch | | | |
| □ | □ | Insulin pump | | | | | | |
| □ | □ | Hearing aid(s) or cochlear implant(s) | | | | | | |

NOTICE: Failure to correctly and thoroughly comply with this questionnaire may place the patient's health in jeopardy as well as compromise the quality of the exam. I consent to the performance of this examination and the administration of contrast media as required to satisfy my physician's request.

## ADDITIONAL QUESTIONS AND SIGNATURE FOR CONSENT ON BACK OF FORM

**TURN OVER →**

YES _____ NO _____ 1. Are you over 65 years old?

YES _____ NO _____ 2. Are you diabetic?

YES _____ NO _____ 3. Do you have/had kidney disease or kidney surgery?

YES _____ NO _____ 4. Have you ever had chemotherapy?*
If yes, when? Month_____ Year_____

YES _____ NO _____ 5. Have you ever had Radiation Therapy?*
If yes, when? Month_____ Year_____

YES _____ NO _____ 6. Do you have a history of multiple myeloma?

YES _____ NO _____ 7. Do you have rheumatoid arthritis?

YES _____ NO _____ 8. Do you have scleroderma, lupus, dermatomyositis, or Wegener's Disease?

YES _____ NO _____ 9. Do you have AIDS/HIV?

**Patient Signature: _____ DATE: _____**

**IF THE PATIENT ANSWERS YES TO ANY ONE OF THESE QUESTIONS, WE MUST HAVE A CREATININE WITHIN THE PAST 30 DAYS.**
** Creatinine only needed for patients who have had chemotherapy or radiation therapy within the past 3 months.*

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## TO BE FILLED OUT BY MRI STAFF:

Technologist: _____ DATE: _____

**Creatinine: _____ Creatinine Clearance: _____**

**Creatinine Clearance Between 30 and 60 Approved by**: _____

**CONTRAST:**
PRODUCT: _____ LOT: _____ EXP DATE: _____ AMT: _____

**APPROVAL OF ANY METALLIC HARDWARE: _____**

**PREVIOUS MRI SCANS? (Please circle) YES NO DATE _____**

**If yes, where? PACS ON CART OUTSIDE FACILITY MJ PURGED**

**COMPARISON X-RAYS TODAY? (Please circle) YES NO**

**PRIOR COMPARISON X-RAYS? (Please circle) YES NO DATE _____**

**If yes, where? PACS ON CART OUTSIDE FACILITY MJ PURGED**

**TURN OVER →**