



PATIENT SCREENING FORM

Phone (Local): 208-947-7002
Phone (Toll Free): 877-674-6625

www.mrici.com

Fax (Local): 208-947-7001
Fax (Toll Free): 800-657-6410

Briefly describe your symptoms and indicate how long you have had these symptoms of the **area being imaged**:

1. Did you have an injury? How? _____ Injury date, if known: _____
2. Decreased range of motion? Yes No Popping in the joint? Yes No Was the joint ever dislocated? Yes No
3. Do you have a lump that you can feel? Yes No If so, please describe area: _____
4. Do you have arthritis? Yes No Type of arthritis: _____
5. Has your physician done any injections to the area being imaged? Yes No If so, when? _____
6. Have you had prior surgery or an operation of any kind to the **area being imaged**? Yes No If yes, please list:
Date: _____ Type of surgery: _____

7. Have you had a prior diagnostic imaging study or examination (MRI, Ultrasound, X-Ray, etc.)? Yes No

Imaging Modality	Body Part	Date	Facility
MRI			
CT/CAT Scan			
X-Ray			
Ultrasound			
Nuclear Medicine			
Other			

8. Are you currently taking or have you recently taken any medication or drugs? Yes No

If yes, please list: _____

9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal failure, renal transplant, dialysis, high blood pressure (hypertension), liver (hepatic) disease or seizures? Yes No

If yes, please describe: _____

All medical procedures carry an element of risk, and MRI is no exception. The use of contrast material may provide additional information to evaluate your condition and improve the quality of your examination. Most people have no ill effects from the contrast. Sometimes mild reactions do occur, but pass without treatment or respond quickly to medication. The risks or reactions associated with the contrast injection may include but are not limited to headache, nausea, itchiness and discomfort at the site of injection. Additional adverse events occur in less than 1% of patients. Rarely a more severe allergic reaction to the dye could occur, such as severe difficulty breathing, or shock. Prompt treatment may be required should a severe reaction occur. There is a very slight chance of coma and death. Please inform the technologist if you feel discomfort or experience any of these symptoms. Your physician has considered the potential risks before recommending the use of contrast, and believes the diagnostic benefits outweigh the potential risks.

I HAVE READ THE ABOVE STATEMENT AND GIVE MY CONSENT TO THE PERFORMANCE OF THE MRI PROCEDURE ORDERED, INCLUDING THE ADMINISTRATION OF CONTRAST MATERIAL, IF INDICATED.

PATIENT NAME (PLEASE PRINT): _____ DATE: _____

DOB: _____ HEIGHT: _____ WEIGHT: _____

SIGNATURE OF PATIENT/REPRESENTATIVE: _____

PATIENT UNABLE TO SIGN DUE TO: _____

PERSON COMPLETING FORM: _____ RELATIONSHIP TO PATIENT: _____

Certain implants and devices may be hazardous to you and/or may interfere with the MR procedure. Do not enter The MR system room if you have any questions regarding an implant, device, or object. Before entering the MR environment you must remove all metallic objects including hearing aids, dentures, partial plates, keys, pager, cell phone, hairpins, jewelry, body piercing jewelry, watch, safety pins, credit cards, (any card with a magnetic strip), pocket knife, nail clippers, and tools. Consult the MR technologist BEFORE entering the MR system room! **NOTE:** You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

DO YOU HAVE:	YES	NO	COMMENTS
Cardiac (heart) Pacemaker or defibrillator?			If yes, STOP here and notify MRI staff.
Neurostimulator (TENS unit) or electrode implant?			
Electronic implant or device?			
Magnetically activated implant or device?			
Spinal cord stimulator?			
Bone growth/bone fusion stimulator?			
Insulin or other infusion pump? OR Implanted drug infusion device?			
Swan-Ganz or thermodilution catheter?			
Known or possible metal fragments in the eye, head, or body (i.e. welders, machinists, sheet metal workers, etc.)?			
Heart valve prosthesis?			
Stent, filter, or coil?			
Vascular access port and/or catheter?			
Aneurysm clips?			
Shunt (spinal or ventricular)?			
Ear surgery or middle ear prosthesis (implant)?			
Eyelid spring or wire/orbital (eye) prosthesis (implant)?			
Hearing aid?			
Dentures?			
If yes, are they held in place with magnets?			
Permanent tattoo or eyeliner? Any metallic eye shadow?			
Body piercing jewelry?			
IUD (intrauterine device)?			
Known or possible pregnancy?			
Breast feeding?			
Radiation seeds or implants?			
Medication patch (nicotine, nitroglycerine, etc.)?			
Wire mesh implant?			
Tissue expander (i.e. breast)?			
Surgical staples, clips, or metallic sutures?			
Metal rod, pin, screw, nail, wire, plate, penile implant, etc?			
Joint or limb replacement?			
War injury or gunshot wound? BB's: bullets?			
History of diabetes?			
Respiratory disorder?			
Allergies to drugs?			
Previous reaction to contrast material?			
Asthma or emphysema?			
Do YOU have a history of cancer?			
Surgery in the last 6 weeks?			

History of other surgeries or medical problems. Please list:

Technologist Review (Please Sign): _____

Patient Name (Print): _____ DOB: _____