Turville Bay MRI and Radiation Oncology Center – MRI Procedure Screening Form

Name _____ Birth Date _____ Height & Weight _____
Last Name, First Name M.I.

1. Have you ever had surgery in the area we are scanning? ☐ YES ☐ NO
   If yes, please list type: _____ Date: _____/_____/_____
2. Have you ever been treated for any serious medical disease/condition? ☐ YES ☐ NO
   If yes, please list type: _____ Date: _____/_____/_____
3. Have you had any previous imaging studies of the area to be scanned? ☐ YES ☐ NO
   If yes, please list type: _____ _____ Date: ____/_____/_____
   (MRI, CT, Xray, etc) (Location)
4. Do you have any drug allergies or prior reactions to CT or MRI Contrast?
   If yes, please list type: _____ ☐ YES ☐ NO
5. Do you have a history of Sleep Apnea? ☐ YES ☐ NO
6. Have you taken any pain or sedative medication today? ☐ YES ☐ NO
7. If you answered Yes to question 6 and are taking a sedative medication, do you have a designated driver? ☐ YES ☐ NO

Please call if you answer YES to any of the following questions. 608-258-7820 or 1-800-843-1173.
Some of the following items may be hazardous to your safety and some can interfere with the MRI examination.

- Have you ever had an **injury to the eye involving a metallic object** (e.g., metallic slivers, shavings, or foreign body) and had it removed by a physician? ☐ YES ☐ NO
- Have you ever been **injured by a metallic foreign body** (e.g. BB,buckshot,shrapnel)? ☐ YES ☐ NO
  If yes, please describe: _____

Please circle YES or NO for each of the following.

***** Absolute contraindications**

Yes No Cardiac pacemaker ***
Yes No Implanted cardiac defibrillator ***
Yes No Stent, coronary or vascular (call clinic)
Yes No Aneurysm Clip in head/neck (call clinic)
Yes No Currently on dialysis/kidney disease
Yes No Pre/Post Liver Transplant
Yes No Hypertension
Yes No Diabetes
Yes No Endoscopy/Colonoscopy in last 2 mos.
Yes No Intravascular Filter or Coil
Yes No Carotid artery vascular clamp
Yes No Neurostimulator
Yes No Insulin or Drug Infusion pump/device
Yes No Bone growth/fusion stimulator
Yes No Eye or Ear implant (excluding cataract)
Yes No Heart Valve prosthesis
Yes No Internal pacer wires
Yes No Aortic clips (Heart)
Yes No Shunt with Programmable Valve
Yes No Artificial limb/Joint or Joint Replacements (bone/joint pins, wires, screws, nails, plates)

Please List: _____

Yes No Vascular access port and/or catheter
Yes No Possibility of pregnancy or breast feeding
Yes No Any implant held in place by a magnet (eye)
Yes No Electrodes (on body, head, or brain)
Yes No Transdermal delivery system (Nitro-patch, etc)
Yes No IUD or (diaphragm in place at time of scan)
Yes No Tattoos, tattooed eyeliner or eyebrows/body piercing
Yes No Breathing disorder (Asthma, COPD, etc)
Yes No Motion disorder (i.e. tremors)
Yes No Claustrophobia
Yes No Special needs/O2/wheelchair
Yes No Hearing Aid/Removable Dental work (You will be asked to remove prior to scan)
Yes No Any Metal or Implanted Device/Prosthesis in body not listed above
Please List: _____

Yes No Any Surgery or Procedure within last 6wks
Please List: _____

To protect your hearing, we will provide earplugs or headphones that you are required to wear during the MRI examination.

_____ Date _____/_____/_____
Signature of Person Completing Form

Form Completed/Interpreted by: ☐ Other ☐ Relative: _____
Name & relationship to patient

Reviewed by Technical Staff: _____ Date _____/_____/_____

Revised 03/2015