

MRI SCREENING RECORD DELANEY RADIOLOGISTS

ATTN _____

CALL REPORT _____ **Referring #** _____

Previous Exams: _____

On Pacs: _____

Images _____

Name: _____

Date: _____ DOB: _____

Drug Allergies: Yes No If yes, list: _____

Your doctor has ordered an MRI examination to help determine your diagnosis. The following items can interfere with MRI imaging and some can be hazardous to your safety. **Please check the appropriate boxes:**

	YES	NO		YES	NO
HEART PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	SPINE SURGERY	<input type="checkbox"/>	<input type="checkbox"/>
ANEURYSM CLIP / BRAIN	<input type="checkbox"/>	<input type="checkbox"/>	METAL PINS / SCREWS OR RODS	<input type="checkbox"/>	<input type="checkbox"/>
CAROTID CLIP	<input type="checkbox"/>	<input type="checkbox"/>	SURGERY WITHIN LAST SIX WEEKS	<input type="checkbox"/>	<input type="checkbox"/>
IMPLANTED DEFIBRILLATOR	<input type="checkbox"/>	<input type="checkbox"/>	What Kind? _____		
NEUROSTIMULATOR / TENS UNIT	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU CLAUSTROPHOBIC?	<input type="checkbox"/>	<input type="checkbox"/>
EAR SURGERY / COCHLEAR, STAPES IMPLANT ...	<input type="checkbox"/>	<input type="checkbox"/>	COULD YOU BE PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
ARTIFICIAL HEART VALVE	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU BREAST FEEDING?	<input type="checkbox"/>	<input type="checkbox"/>
METAL IN EYES AND / OR METAL WORKER	<input type="checkbox"/>	<input type="checkbox"/>	EYE LINER TATTOO	<input type="checkbox"/>	<input type="checkbox"/>
(Please check yes if you have ever had metal in your eye(s))			BODY PIERCING	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGY TO LATEX	<input type="checkbox"/>	<input type="checkbox"/>
BRAIN SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	DRUG PATCHES	<input type="checkbox"/>	<input type="checkbox"/>
SHRAPNEL / BULLETS	<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF CANCER	<input type="checkbox"/>	<input type="checkbox"/>
INFUSION PUMP	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU SMOKE?	<input type="checkbox"/>	<input type="checkbox"/>
PENILE PROSTHESIS	<input type="checkbox"/>	<input type="checkbox"/>	IF NO, HAVE YOU EVER SMOKED?	<input type="checkbox"/>	<input type="checkbox"/>
BREAST IMPLANT / TISSUE EXPANDER	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, HOW MANY PACKS PER DAY? _____		
JOINT REPLACEMENT	<input type="checkbox"/>	<input type="checkbox"/>	FOR HOW LONG? _____		

DO NOT ENTER THE MAGNET ROOM WITH ANY OF THE FOLLOWING:

- | | | | | |
|------------------------|-----------|-----------|--------------|--------------|
| Heart Pacemaker | Watches | Keys | Credit Cards | Coins |
| Hearing Aid / Dentures | Hair Pins | Barrettes | Pens | Pocket Knife |
| Any Electronic Device | Jewelry | Earrings | Belts | Safety Pins |

CREATININE TESTING

For MR exams requiring IV contrast, a serum creatinine level within the last 30 days is required for patients with any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Hypertension (or meds for HTN) | <input type="checkbox"/> Kidney Disease / Solitary Kidney | <input type="checkbox"/> Multiple Myeloma |
| <input type="checkbox"/> History of Cancer/Chemotherapy (within last 30 days) | <input type="checkbox"/> Pheochromocytoma | <input type="checkbox"/> None _____ (initials) |

_____ CREATININE _____ LOCATION & DATE DRAWN (must be within last 30 days)

DELANEY TO PROVIDE CREATININE TESTING ON DAY OF EXAM _____ I-STAT CREATININE

GADOLINIUM

The radiologist may deem it necessary to give you the I.V. injection of a contrast liquid containing gadolinium to improve the quality of your MR examination. Although gadolinium contrast agents have been used safely in millions of patients, minor reactions (principally headache or nausea) occur in 2% of patients, and serious or life-threatening reactions have been reported in 1 in 400,000 patients.

History of previous reaction: Yes No

If yes, explain: _____

Asthma or emphysema: Yes No

Pt. Weight: _____

Sickle Cell Anemia: Yes No

Technologist Use Only

Manuf: _____ Lot #: _____

Amount: _____ Exp. Date: _____

Injection Site: _____

Injected by: _____

I have answered the above questions to the best of my understanding and will not knowingly enter the magnet room with any of the above items.

Patient Signature _____ Date _____

Technologist Signature _____ Date _____