OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE



## MRI PATIENT SCREENING TOOL

PLEASE PRINT CLEARLY

Date: _____ Patient Name: _____

Birth date: _____ MR#: _____ Reason for MRI Screening:

Have you taken any sedation/alcohol today to relax you for this procedure? ☐ No ☐ Yes (what): _____

If yes, do you have someone to drive you home? ☐ No ☐ Yes

## MRI CONTRAST HISTORY ☐ NOT APPLICABLE TO THIS EXAM

Have you ever had MRI contrast? ☐ No ☐ Yes

Do you have any history of kidney (renal) insufficiency or failure? ☐ No ☐ Yes

Are you diabetic? ☐ No ☐ Yes Do you have a history of hypertension? ☐ No ☐ Yes

Did you have any kind of reaction? ☐ No ☐ Yes (explain):

## FOR FEMALE PATIENTS

Are you taking oral contraceptives or receiving hormonal treatment? ☐ No ☐ Yes

Are you currently breastfeeding? ☐ No ☐ Yes

Are you using or have you ever used implanted birth control, such as IUD or cervical ring? ☐ No ☐ Yes

| DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (IF YES, EXPLAIN) | | |
|---|---|---|
| Cardiac Pacemaker | ☐ No ☐ Yes | |
| Heart surgery/heart valve | ☐ No ☐ Yes | |
| Tissue expanders (i.e. Breast) | ☐ No ☐ Yes | |
| Brain aneurysm clips/brain surgery | ☐ No ☐ Yes | |

| | | If yes, explain |
|---|---|---|
| Shunts/stents/filters/intravascular coil | ☐ No ☐ Yes | |
| Staples | ☐ No ☐ Yes | |
| Eye surgery/implants/spring/wires/ retinal tack | ☐ No ☐ Yes | |
| Injury to the eye involving metal or metal shavings | ☐ No ☐ Yes | |
| Orthopedic Pins/screws/rods/joints/ prosthesis | ☐ No ☐ Yes | |
| Neurostimulator/biostimulator | ☐ No ☐ Yes | |
| Radiation therapy/chemotherapy | ☐ No ☐ Yes | |
| Previous back surgery (lumbar/ thoracic/cervical) | ☐ No ☐ Yes | |
| Ear surgery/cochlear implants/ hearing aids/stapes prosthesis | ☐ No ☐ Yes | |
| Vascular access port/catheter | ☐ No ☐ Yes | |
| Electrical/mechanical/magnetic implants | ☐ No ☐ Yes | |
| Metal mesh implants/wire sutures/ wire staples or clips/internal electrodes | ☐ No ☐ Yes | |
| Implanted drug infusion pump/insulin pump | ☐ No ☐ Yes | |
| Tattoos/permanent make-up/body piercing/patches | ☐ No ☐ Yes | |
| Gunshot wounds/shrapnel/BB | ☐ No ☐ Yes | |
| Do you have pins in your hair/clothes/ hair extensions/hair pieces/wig | ☐ No ☐ Yes | |
| Dentures/partials/dental implants | ☐ No ☐ Yes | |
| History of work involving welding or grinding of sheet metal | ☐ No ☐ Yes | |
| History of cancer or tumors | ☐ No ☐ Yes | When:<br>Where: |

**ATTENTION! The items listed on the previous pages can affect the quality of the MRI exams and may cause safety hazards. Presence of these items may influence the way we perform your examination. Please review your responses before initialing below.**

I DO NOT HAVE ANY OF THE PREVIOUSLY LISTED ITEMS. _____ (patient to initial here)

Note: Any "Yes" answers are to be reviewed with the MRI Radiologist before prior to scan.

## PLEASE REMOVE ANY METAL OBJECTS FROM YOUR PERSON, INCLUDING, BUT NOT LIMITED TO:

- Body piercings
- Pens & pencils
- MP3 players
- Steel tools
- Pagers
- Keys/key fobs
- Identification badges
- Contraceptive diaphragms
- Tools
- Credit cards
- Wristwatch
- Cell phones
- Any other electrically, magnetically, or mechanically activated devices
- Sharp objects (i.e. scissors, pocket knife, nail file, nail clippers)
- Restraining devices or radiofrequency ID/tracking bracelets
- Drug delivery patches
- Paper clips
- Jewelry

## SCREENED BY (2 STAFF SIGNATURES REQUIRED, PLEASE PRINT & SIGN)

1st Staff Member: _____ Date:_____

2nd Staff Member: _____ Date:_____

I attest that the above information is correct to the best of my knowledge. I have also informed the technologist that I am not pregnant at this time and I give consent to have a contrast agent administered to me if needed for proper diagnosis of my procedure. I acknowledge that I am aware of the possibility of side effects with contrast and I have had the opportunity to ask questions related to this form, to ask questions regarding the MRI procedure, and I understand the information presented to me.

Patient/Parent/Legal Guardian: _____ Date:_____

MRI Technologist:_____ Date:_____