



PATIENT SCREENING FORM

Questionnaire and Consent

Patient Name: _____
Last First MI

DOB (mm/dd/yyyy): _____ Weight (lbs.): _____ Sex: M F

- Yes No Do you have any **prior studies** with you that were done on the **same body part**?
- Yes No Are you **claustrophobic**?
- Yes No Do you have or ever had **cancer**?
If yes, list type and treatment(s) _____
- Yes No Have you ever had an injury to your eyes involving metal?
- Yes No Do you have body piercings? If yes, where? _____
- Yes No Do you have a medication patch? (e.g. nitroglycerine, nicotine) If yes, where? _____
- Yes No Do you have a history of asthma, or other allergic respiratory disease?
If yes, please describe: _____
- Yes No Are you **diabetic**? If yes, what type? _____
- Yes No Do you have a history of **renal/kidney disease**?
- Yes No Have you ever had a kidney removed?
- Yes No Are you on dialysis? If yes, when are you scheduled to be dialyzed again? _____
- Yes No Do you have a history of **liver disease** or **failure**?
If yes, have you had or scheduled to have a liver transplant? If so, when? _____

Please indicate if you ever had or have any of the following:

- Yes No **Aneurysm clip(s)**
- Yes No **Cardiac Pacemaker or Defibrillator**
- Yes No **Electronic implant or device**
- Yes No **Magnetically-activated implant or device**
- Yes No **Neurostimulation system**
- Yes No **Cochlear implant or implanted hearing aid**
- Yes No **Insulin or infusion pump**
- Yes No **Implanted drug infusion device**
- Yes No **Any type of prosthesis or implant**
- Yes No **Any metallic fragment or metallic foreign body**
- Yes No **Any chance of PREGNANCY**
- Yes No **Other implant** _____
- Yes No **Other device, ie. hearing aids** _____
- Yes No **Surgeries; if yes, please list below:**



IMPORTANT INSTRUCTIONS

Remove all metallic objects **BEFORE** entering the MR environment or MR system room including hearing aids, beeper, cell phone, keys, eyeglasses, hair pins, barrettes, jewelry (including all body piercing jewelry), watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, steel-toed boots/shoes, and tools. Loose metallic objects are especially prohibited in the MR system room and MR environment. Please consult the MRI Technologist or Radiologist if you have any question or concern before you enter the MR system room.

****We encourage you to contact us at 703-478-0922 with any questions you may have about this form or your procedure.****

Consent Statement

I understand the accuracy of this screening is essential to my safety in the MRI environment and that MRI is contraindicated in some instances. Frequently a contrast agent needs to be used with the MRI scanning process Optimark is the brand we use and is FDA approved for MRI. However, patients who are pregnant, breast feeding, have sickle cell anemia, or have severe renal impairment should inform the technologist prior to the scanning procedure.

I, the undersigned, or parent / legal guardian (if under 18) have read and understand the above, and have provided the necessary information to the best of my knowledge.

Patient, Parent or Legal Guardian Signature Date Reviewed By Date

Thank You!