Oaklawn

**Patient Name:** _____ **Patient Weight:** _____
**Patient DOB:** ____/____/____ **Exam Ordered:** _____
**Reason for exam:** _____
_____

| Please check "yes" or "no" for the following questions: | Yes | No |
|---|---|---|
| Are you claustrophobic? | | |
| Have you had a previous reaction to MRI contrast dye? | | |
| Have you ever been injured by a metallic foreign body? (Shrapnel, BB, bullet) | | |
| Have you had any injury involving metallic shavings to the **eye**? | | |
| Do you have a personal history of cancer? If yes, what type: | | |
| Do you wear an insulin pump or glucose monitor? | | |
| Have you had a colonoscopy/endoscopy procedure within the last 60 days where clips were placed? | | |
| Have you ingested any endoscopy capsules (pill cam) in the last 30 days? | | |
| Do you have any of the following: asthma, kidney disease, diabetes, breathing disorders, anemia, or high blood pressure? Circle all that apply. | | |
| Do you have anything in, on, or attached to your body you were told not to go through airport security with? | | |

| Do you have any of the following implanted or attached to your body? | Yes | No |
|---|---|---|
| Aneurysm clips | | |
| Implanted cardiac pacemaker/defibrillator | | |
| Neuro, bone growth, or spinal cord stimulator | | |
| Internal electrodes or wires | | |
| Cochlear, otologic, or other ear implant | | |
| Drug infusion pump | | |
| Prosthesis (eye, penile, limb, etc.) | | |
| Heart valve prosthesis and/or IVC filter | | |
| Heart, brain, abdominal, or leg stent(s), coils, or filters | | |
| Shunt or mechanically, electronically, or magnetically activated device | | |
| Eyelid spring, wire, or weight | | |
| Joint replacement(s) | | |
| Implanted birth control, IUD, diaphragm, or pessary | | |
| Vascular access port/catheter | | |
| Radiation seeds or implants | | |
| Swan-Ganz or thermodilution catheter | | |
| Bladder sling, surgical mesh, or hernia mesh | | |
| Tissue expander (e.g., breast) | | |
| Pins, screws, plates, wires, clips, staples, or other metals | | |
| Spinal fixation device or spacer | | |
| Dentures, partial plates, or removable dental work | | |
| Wound dressing or non-healing wounds | | |
| Hearing aids | | |
| Body piercings/jewelry | | |
| Tattoos or permanent makeup | | |
| Medication patch (lidocaine, nicotine, fentanyl, estrogen, etc.) | | |
| Other implant (Please list if applicable) | | |

**CONTINUED ON OTHER SIDE**

**WARNING:** **The MR system magnet is ALWAYS on! Certain metallic, electronic, magnetic, or mechanical implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. Therefore, all individuals are required to fill out this form BEFORE entering the MR environment or MR system room. Do not enter the MR system room or MR environment if you have any question or concern regarding any implant, device or object. Always Consult the MRI Technologist or Radiologist BEFORE entering the MR system room.**

## Please list ALL surgeries or procedures you have undergone:

** Please present all implant cards from prior procedures **

| Date: | Procedures (including implanted surgical staples, clips, etc.) |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| |
|---|
| Are you currently undergoing any type of fertility or hormonal treatments and/or taking oral contraceptives? Y / N |
| ****Female patients only** |
| Are you post-menopausal? Y / N **If yes, stop here* |
| Date of last menstrual cycle: / / |
| Are you currently breastfeeding? Y / N |
| Is there **any** possibility you could be pregnant? Y / N |

**CONTRAST:** Your physician or radiologist may deem it necessary for you to have an IV injection of a contrast agent 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), and serious life-threatening reactions may occur. I have read and understand the above information and have had my questions answered. I agree to have the injection of contrast if deemed necessary.

**Signature:** _____ **Date:** _____

I attest that all information on this form is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form and the MR procedure that I am about to undergo. I acknowledge that I have turned off and/or removed my device(s) per vendor specifications.

**Signature:** _____ **Date:** _____

**Form completed by:** □ Patient □ Relative □ Nurse _____ _____
Name Relation

**Reviewed by - Technologist**: _____ **Patient scanned at:** □ First Level □ Normal Mode □ Low Sar