MRI SCREENING FORM

DuPage Medical Group
WE CARE FOR YOU

Location _____ Exam date _____ Scheduler's initials _____

Last name _____ First name _____ GE# _____
Date of birth _____ Height _____ Weight _____
Who is your ordering physician? _____

☐ Yes ☐ No Have you had any previous tests for the body part on which we are doing the scan today?

MRI	Date _____	Facility location _____
CT/CAT scan	Date _____	Facility location _____
X-ray	Date _____	Facility location _____
Ultrasound	Date _____	Facility location _____
Nuclear medicine	Date _____	Facility location _____

Please review the following answers you provided when scheduling your test.

☐ Yes ☐ No Claustrophobia
☐ Yes ☐ No Cardiac pacemaker, pacing wires or defibrillator
☐ Yes ☐ No Carotid artery, vascular clip/clamp (aortic etc)
☐ Yes ☐ No Aneurysm clip(s) or shunt
☐ Yes ☐ No Neurostimulator/biostimulator
Manufacturer _____ Model# _____
Manufacturer _____ Model# _____
☐ Yes ☐ No Internal or external pumps (insulin, infusion, etc.)
☐ Yes ☐ No Any type of prosthesis (eye, ear, penile, etc.)
Type _____
☐ Yes ☐ No Artificial Limb(s)
☐ Yes ☐ No Implants, stents or artificial valves
Type _____ When _____
Manufacturer _____ Model _____
☐ Yes ☐ No IUD or Diaphragm
☐ Yes ☐ No Shrapnel or bullets
☐ Yes ☐ No Metallic injury to the eye
Was it removed by a physician? ☐ Yes ☐ No
☐ Yes ☐ No Hearing aids (must be removed prior to exam start)
☐ Yes ☐ No Tissue expanders (breast)

☐ Yes ☐ No Asthma
☐ Yes ☐ No Any allergies which have resulted in an ER visit, hospitalization or intubation?
Reaction source: _____
☐ Yes ☐ No Any contrast reactions
What contrast (CT, MRI): _____
Type of reaction: _____
☐ Yes ☐ No Latex or adhesive allergy
☐ Yes ☐ No Diabetic
If yes, do you take insulin and/or oral medication? Yes ☐ No ☐
☐ Yes ☐ History of kidney disease, kidney failure or renal dialysis
☐ Yes ☐ No Ear or body piercings
☐ Yes ☐ No Tattooed makeup (eyeliner, lips, etc.)
☐ Yes ☐ No Vascular access port and/or catheter
☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate
☐ Yes ☐ No Dental implants (within 6 weeks)
☐ Yes ☐ No If female, chance of pregnancy
LMP _____
☐ Yes ☐ No If female, are you nursing

Medical/surgical history _____

Cancer history _____

☐ Yes ☐ No Do you have anemia, any diseases that affect your blood or a history of renal disease or seizures? (please describe below)

MRI

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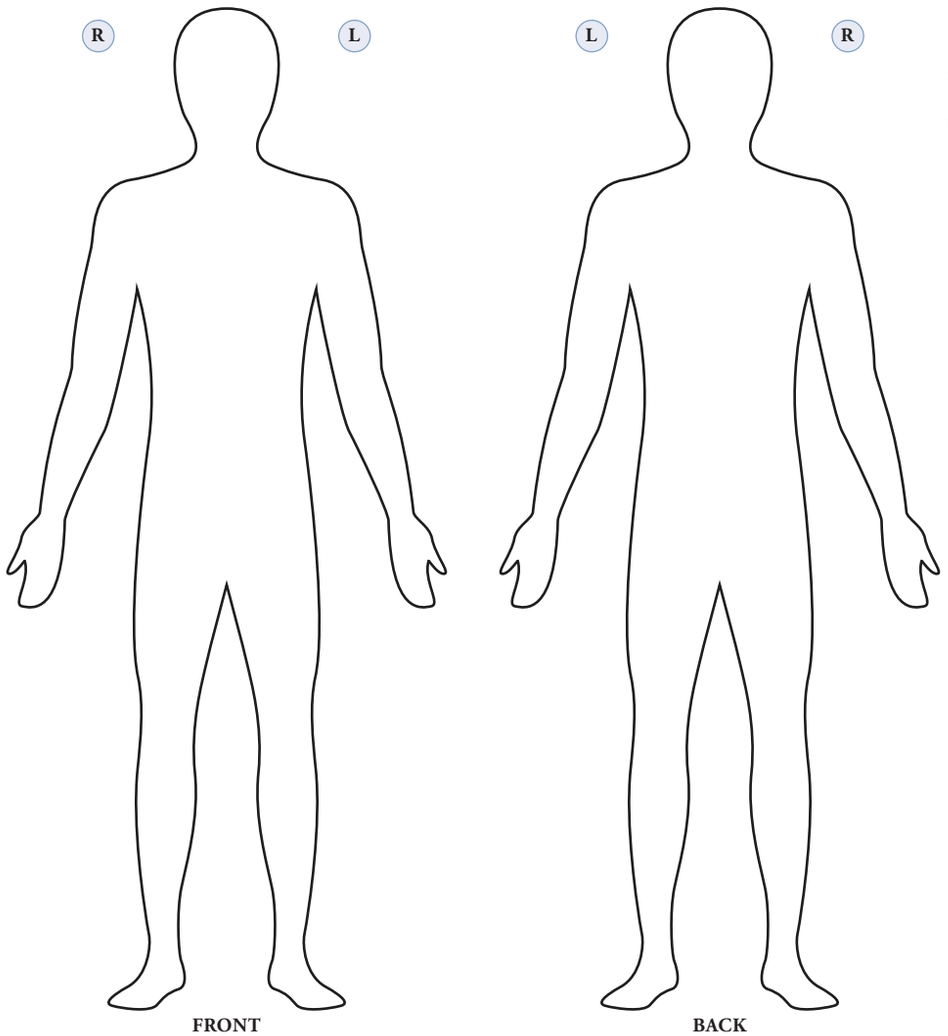
Describe your current pain and/or symptoms

_____

_____

_____

_____



Please indicate on the drawing where the pain is located. Be as specific as possible.

I verify that this information is correct to the best of my knowledge.

Signature of Patient _____ Date _____

Form completed by: (please circle one) Patient Relative Other

Name and relationship to patient _____

Note: You are required to wear earplugs or earphones during the MRI Examination
Some of the following items may be hazardous to your safety and some can interfere with the MRI examination.
Before your MRI, please remove all metallic objects including hearing aids, keys, hair pins, barrettes, jewelry, body piercings, watches, safety pins, paper clips, money clips, credit cards, coins, pens, belts, metal buttons, pocket knives, and clothing with metal in the material.