NEWTON-WELLESLEY HOSPITAL

PATIENT IDENTIFICATION AREA

MRI PATIENT SCREENING FORM

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

Please answer the following Questions:

1. Do you have a **Pacemaker, Pacing Wires, ICD** (Implantable Cardioverter Defibrillator) ❒ Yes ❒ No
2. Have you had an injury to the eye involving a metallic object or fragment (e.g. metallic sliver, shavings, foreign body, etc.), or worked with metal? ❒ Yes ❒ No
   If yes, please describe: _____
3. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast media or 'dye' used for an MRI, CT, or X-ray examination? ❒ Yes ❒ No
   If yes, please list: _____

Please indicate if you have any of the following:

Brain Aneurysm Clip(s) – If Yes, Date of Surgery_____ Name of Hospital_____ ❒ Yes ❒ No
Brain surgery involving metal clips or implants – If Yes, Name of Hospital_____ ❒ Yes ❒ No
Cardiac Pacemaker, Pacing Wires, Implanted Cardioverter Defibrillator (ICD)
Electronic implant or device – If Yes, what type _____ ❒ Yes ❒ No
Magnetically-activated implant or device – If Yes, where ❒ Yes ❒ No

Any metallic fragment or foreign body – If Yes, where _____ ❒ Yes ❒ No
Neurostimulation system – If Yes, what type _____ ❒ Yes ❒ No
Spinal cord stimulator – If Yes, what type _____ ❒ Yes ❒ No
Bone growth/bone fusion stimulator – If Yes, what type _____ ❒ Yes ❒ No
Any type of prosthesis (eye, penile, etc.) – If Yes, where _____ ❒ Yes ❒ No
Heart valve prosthesis – If Yes, what type _____ ❒ Yes ❒ No
Metallic stent filter or coil – If Yes, what type _____ ❒ Yes ❒ No
Radiation seeds or implants – If Yes, where _____ ❒ Yes ❒ No
Wire mesh implant – If Yes, what type _____ ❒ Yes ❒ No
Surgical staples, clips or metallic sutures – If Yes, where_____ ❒ Yes ❒ No
Joint replacement (hip, knee, etc.) – If Yes, where_____ ❒ Yes ❒ No
Bone/joint pin, screw, nail, wire, plate, etc – If Yes, where _____ ❒ Yes ❒ No
Internal electrodes or wires ❒ Yes ❒ No
Cochlear, otologic or other ear implant/surgery ❒ Yes ❒ No
Implanted insulin or other drug infusion device or pump ❒ Yes ❒ No
Eyelid spring or wire ❒ Yes ❒ No
Artificial or prosthetic limb ❒ Yes ❒ No
Shunt (spinal or intraventricular) ❒ Yes ❒ No
Vascular access port and/or catheter ❒ Yes ❒ No
AAA Endovascular Graft ❒ Yes ❒ No
Swan-Ganz or thermodilution catheter ❒ Yes ❒ No
Tissue expander (e.g., Breast) ❒ Yes ❒ No
Breast Implants ❒ Yes ❒ No
IUD, diaphragm, or pessary ❒ Yes ❒ No
Dentures, partial plates, magnetic dental implant ❒ Yes ❒ No
Other implant _____ ❒ Yes ❒ No

Medication patch (Nicotine, Nitroglycerine) **(Remove before entering MRI scan room)** ❒ Yes ❒ No
Hair Wig or Hair Extensions **(MAY need to be Removed before entering MRI scan room)** ❒ Yes ❒ No
Body piercing jewelry **(Remove before entering MRI scan room)** ❒ Yes ❒ No
Hearing aid **(Remove before entering MRI scan room)** ❒ Yes ❒ No
Tattoo or permanent makeup – If Yes, where _____ ❒ Yes ❒ No
Breathing Problems or Motion disorder ❒ Yes ❒ No
Claustrophobia or anxious ❒ Yes ❒ No

FOR FEMALE PATIENTS:

4. Date of last menstrual period: ____/____/____ Post Menopausal? ❒ Yes ❒ No
5. Are you pregnant? ❒ Yes ❒ No
6. Are you experiencing a late menstrual period? ❒ Yes ❒ No
7. Are you taking oral contraceptives or receiving hormonal treatment? ❒ Yes ❒ No
8. Are you taking any type of fertility medication or having fertility treatments? ❒ Yes ❒ No
   If yes, please describe: _____
9. Are you currently breast-feeding? ❒ Yes ❒ No

Continue on back

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Kidney/Liver Function Questions

Are you currently on dialysis? ❒ Yes ❒ No

If Yes, when is your next dialysis?_____

Do you have any of the following conditions? **If yes please check each** ❒ Yes ❒ No

❒ Kidney disease
❒ Family history of kidney failure(polycystic)
❒ Lupus
❒ Diabetes: managed with medications
❒ Multiple myeloma
❒ Chronic liver disease

Medication Questions

1 Have you taken any nonsteroidal anti-inflammatory drugs(NSAIDS) ❒ Yes ❒ No
e.g., Aleve/Anaprox.Naprosyn (Naproxen), Celebrex (celecoxib), Motrin/Advil (ibuprofen), Indocin/Indomethacin within the last 24 hours.
If yes, have you taken this/these medication(s) for 4 consecutive days? ❒ Yes ❒ No

2. Have you taken any of the following antibiotics intravenously for 2 or more days? ❒ Yes ❒ No
❒ Amikacin ❒ Gentamicin ❒ Tobramycin ❒ Vancomycin

3. Have you taken the antifungal drug Amphotericin B (not including Ambisome) intravenously for 2 days or more? ❒ Yes ❒ No

4. Have you taken the chemotherapy drug Methotrexate within the past 3 days? ❒ Yes ❒ No

5. Have you taken the chemotherapy drug Cisplatin within the past 3 weeks? ❒ Yes ❒ No

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form, and regarding the MRI procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date _____

Form Completed By: ❒ **Patient** ❒ **Nurse** _____ ❒ **Relative** _____
Print Name Relationship to Patient

MRI Staff Use

Form Information Reviewed By:_____ _____
Print Name MRI Technologist Signature

IV Inserted by:_____ IV Gauge/type_____ ❒ Left ❒ Right_____ Scanned By ____

Type of Contrast_____ Amount_____ Lot Number_____ Exp. Date_____