

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ OMRI Medical Record Number \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Last Name First Name Middle Initial

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Male  Female

Body Part to be Imaged \_\_\_\_\_ If applicable, which body part?  Left  Right

Reason for MRI and/or Symptoms \_\_\_\_\_

How long have you been having these symptoms? \_\_\_\_\_

**WARNING**

Certain implants, devices or objects may be hazardous to you and/or interfere with the MRI procedure (i.e. MRI, MR Angiography, functional MRI, MR spectroscopy). Do Not Enter the MRI scan room or environment if you have any questions or concerns regarding an implant, device or object. Always consult the MRI Technologist BEFORE entering the MRI scan room.

Yes  No Do you have a Pacemaker, Pacing Wires, ICD (Implantable Cardioverter Defibrillator)

Yes  No Brain Aneurysm Clip(s), coil or graft

**If Yes – Date of Surgery \_\_\_\_\_ Name of Hospital \_\_\_\_\_**

Yes  No Cochlear, otologic or other ear implant/surgery

Yes  No Have you received dialysis for kidney/renal failure

Yes  No Do you have any of the following conditions, If **YES** mark what you do have:

Kidney diseases / surgery  Diabetes  Lupus  Acute Kidney Injury  Sickle Cell Anemia

1. Have you had prior imaging of any kind to the area being scanned? (X-ray, CT, MRI, Ultrasound or PET)  Yes  No  
 Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Type of Exam \_\_\_\_\_  
 Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Type of Exam \_\_\_\_\_
2. Have you had prior surgery of any kind to the area being scanned?  Yes  No  
**If Yes, please indicate the date and type of surgery:**  
 Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Type of Surgery \_\_\_\_\_  
 Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Type of Surgery \_\_\_\_\_
3. Do you have a personal history of cancer?  Yes  No  
**If Yes, what type:** \_\_\_\_\_
4. Are you allergic to any medications/ drugs?  Yes  No  
**If Yes, please list:** \_\_\_\_\_
5. Have you ever had a reaction to contrast material or “dye” used for a MRI, CT or X-ray examination?  Yes  No  
**If Yes, please explain:** \_\_\_\_\_
6. Do you have asthma, seasonal allergies, allergic reactions or respiratory disease?  Yes  No  
**If Yes, please explain:** \_\_\_\_\_
7. Do you have claustrophobia or anxiety regarding your MRI examination?  Yes  No  
**If Yes, please explain:** \_\_\_\_\_
8. Are you taking any medication to help you through the exam due to claustrophobia?  Yes  No  
**If Yes, please list:** \_\_\_\_\_
9. Will you be able to lie flat for at least 45 minutes?  Yes  No
10. Do you have breast implants?  Yes  No  
**If Yes,  Saline  Silicone**

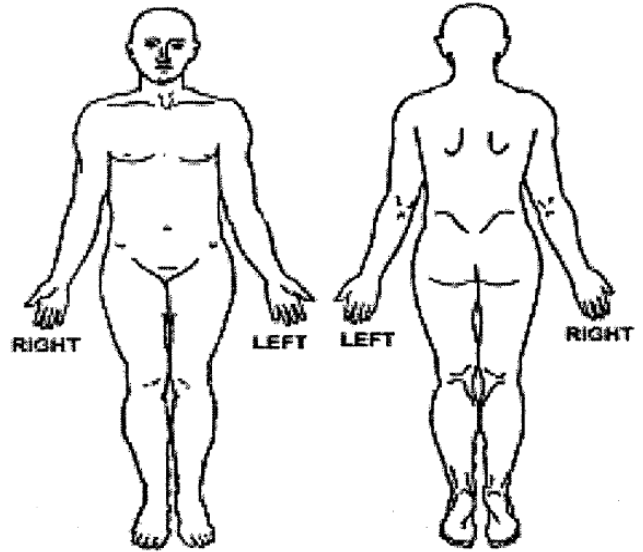
**For female patients:**

11. Date of last menstrual period: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Peri-menopausal  Post-menopausal
12. Are you pregnant or is there any chance that you could be pregnant?  Yes  No
13. Are you experiencing a late menstrual period?  Yes  No
14. Are you currently breast-feeding?  Yes  No
15. Do you have an IUD, Diaphragm or Pessary?  Yes  No  
**If Yes, what type:** \_\_\_\_\_
16. Are you receiving hormonal treatment?  Yes  No  
**If Yes, please describe (Tamoxifen, Aromatase Inhibitors, etc):** \_\_\_\_\_

**Please indicate if you have any of the following:**

- Yes  No Internal Electrodes or Wires
- Yes  No Electronic/magnetically activated implant
- Yes  No Eyelid Spring, wire or weight
- Yes  No Metallic stent or filter
- Yes  No Vascular Access Port and/or Catheter
- Yes  No Shunt (Spinal or Intraventricular)
- Yes  No Any type of internal stimulator
- Yes  No Implanted drug infusion device or pump
- Yes  No Bone/Joint pin, screw, nail, wire, plate
- Yes  No Joint replacement (knee, hip, etc.)
- Yes  No Surgical staples, clips or metallic sutures
- Yes  No Wire mesh
- Yes  No Radiation seeds or implants
- Yes  No Any type of prosthesis (limb, eye, penile, etc.)
- Yes  No Tissue expander
- Yes  No Injury/removal of metallic object/fragment from eyes
- Yes  No Injury by a metallic object or foreign body
- Yes  No Tattoo or permanent makeup
- Yes  No Breathing problems or motion disorder
- Yes  No Heart valve
- Yes  No Other implants
- Yes  No Dentures or partial plates

Please mark on the figure(s) below the location of any **implant or metal** inside of or on your body.



**These items must be removed prior to entering the scan room**

- Yes  No Medication Patch (Nicotine, Nitroglycerin, etc.)
- Yes  No Hair pins or Wig
- Yes  No Body piercing jewelry
- Yes  No Hearing aid

**IMPORTANT INSTRUCTIONS**

You **must** change into hospital provided clothing. Ear plugs will be provided and must be worn during the examination. Before entering the MRI environment or MRI system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing, watch, safety pins, paperclips, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clippers and tools.

Please consult with the MRI technologist if you have any questions or concerns **BEFORE** you enter the MRI scan room.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form, and regarding the 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 Only**

Criteria for checking labs not met Lab Exam Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Creatinine Level: \_\_\_\_\_ Estimated Glomerular Filtration Rate (eGFR): \_\_\_\_\_ (via eGFR calculator website)

Contrast Name: \_\_\_\_\_ Contrast Amount: \_\_\_\_\_ (mL) (Confirmed by dose calculation chart)

Contrast Lot Number: \_\_\_\_\_ Injection site:  Left  Right

Reviewed By: \_\_\_\_\_  
MR Technologist Printed Name MR Technologist Signature