OPTIMUM IMAGING CENTER, LLC

WARNING: You must remove ALL metallic objects before entering the MRI Environment. Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy.) DO NOT ENTER the MR system room or MR environment if you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR System Magnet is ALWAYS on.

MRI SCREENING QUESTIONNAIRE

*Name: _____ *DOB: _____ / _____ / _____ MRN: _____

Referring Physician: _____ *Weight: _____ *Sex: _____

Briefly describe your symptoms _____

_____

Any of the following can interfere with MRI. For your safety, please answer completely:

*□□Yes□□□No Are you claustrophobic?□□
*□□Yes□□□No Do you have a Pacemaker?
*□□Yes□□□No Heart Surgery/Heart Valve?
*□□Yes□□□No Brain Surgery/Brain aneurysm clips
*□□Yes□□□No Do you have an implanted defibrillator or electronic device?
*□□Yes□□□No Are you being treated for acute or chronic renal disease or Dialysis
*□□Yes□□□No Do you have acute renal insufficiency of any severity due to hepato-renal syndrome?
*□□Yes□□□No Are you in the perioperative liver transplantation period?
*□□Yes□□□No Ear Surgery/Cochlear implants/Hearing aids: If yes, explain: _____
*□□Yes□□□No Have you ever had back or neck surgery? If yes, explain: _____
*□□Yes□□□No Any history of Cancer or Multiple Sclerosis? If yes, explain: _____
*□□Yes□□□No Do you have Sickle Cell Anemia or other blood disorder?
*□□Yes□□□No Tens Unit/Neurostimulator/Biostimulator/Spinal Cord stimulator/bone growth stimulator
If yes, explain: _____
*□□Yes□□□No Medication Pump/Drug Infusion/Insulin pump? If yes, explain: _____
*□□Yes□□□No Have you ever had an injury involving metal to your eyes? If yes, explain? _____
*□□Yes□□□No Have you ever had eye surgery? If yes, explain: _____
*□□Yes□□□No Shunts/stents/Intravascular Coil? If yes, explain: _____
*□□Yes□□□No Do you have bone pins, screws, nails, plates, etc.? If yes, explain: _____
*□□Yes□□□No Do you have a prosthesis or artificial limb? If yes, explain: _____
*□□Yes□□□No Are you or could you possibly be pregnant? If yes, explain: _____
*□□Yes□□□No Do you have anything removable in your mouth, i.e. Dentures, retainer?
*□□Yes□□□No Do you have permanent Eye Makeup or Tattoos? If yes, explain: _____

Please list or comment on any other metal you have in your body: _____

List all previous surgeries: _____

_____

Consent: I have informed the technologist that I do not have any metallic devices such as a pacemaker, implant, cerebral aneurysm clips in my body or metallic foreign bodies in my eyes. I attest that the answers provided to the questions on this form are correct to the best of my knowledge and understand the information that has been presented to me. The scheduled procedure and contrast administration, if indicated, has been explained. I understand and have had the opportunity to ask questions.

*Patient/Guardian Signature: _____ Date: _____ / _____ / _____

Technologist Signature: _____ Date: _____ / _____ / _____

Tech notes: Technologist Use Only _____

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