

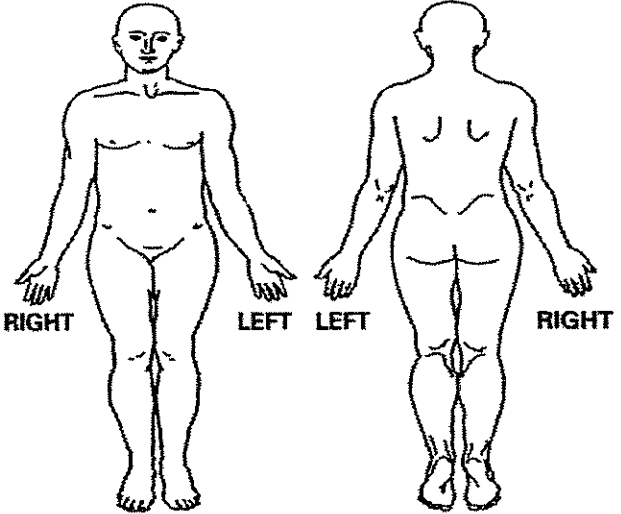


**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR Spectroscopy). **Do not enter** the MR System room or MR environment if you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. **The MR system magnet is ALWAYS on.**

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

- Yes  No Claustrophobia
- Yes  No Aneurysm clip(s)
- Yes  No Any metallic fragment or foreign body (orbits)
- Yes  No Any type of prosthesis (eye, penile, etc.)
- Yes  No Artificial or prosthetic limb
- Yes  No Body piercing jewelry
- Yes  No Bone growth/bone fusion stimulator
- Yes  No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes  No Breathing problem or motion disorder
- Yes  No Cardiac pacemaker
- Yes  No Cochlear, otologic, or other ear implant
- Yes  No Dentures or partial plates
- Yes  No Electronic implant device
- Yes  No Eyelid spring or wire
- Yes  No Hearing aid (Remove before entering MRI room)
- Yes  No Heart valve prosthesis
- Yes  No IUD, diaphragm, or pessary
- Yes  No Implanted cardioverter defibrillator
- Yes  No Implanted drug infusion device
- Yes  No Insulin or other infusion pump
- Yes  No Internal electrodes or wires
- Yes  No Joint replacement (hip, knee, etc.)
- Yes  No Magnetically-activated implant or device
- Yes  No Medication patch (Nicotine, Nitroglycerine)
- Yes  No Metallic stent, filter, or coil
- Yes  No Neurostimulation system
- Yes  No Other Implant \_\_\_\_\_
- Yes  No Radiation seeds or implants
- Yes  No Shunt (spinal or intraventricular)
- Yes  No Spinal cord stimulator
- Yes  No Surgical staples, clips, or metallic sutures
- Yes  No Swan-Ganz or thermodilution catheter
- Yes  No Tattoo or permanent makeup
- Yes  No Tissue expander (e.g., breast)
- Yes  No Vascular access port and/or catheter
- Yes  No Wire mesh implant
- Yes  No Combative or can not hold still for 30 minutes

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



**IMPORTANT INSTRUCTIONS**

Before entering the MR environment or MR 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 jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

**NOTE: Notify MRI immediately if yes to any of the above.**

**NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.**

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 MR procedure that I am about to undergo. If I am to have intravenous contrast with my MRI, I have been informed of the risks of possible allergic reactions and that patients with kidney disease can suffer serious to fatal effects by receiving gadolinium based contrast agents.

Signature of Person Completing Form: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature

Form Completed By:  Patient  Relative  Nurse: \_\_\_\_\_  
Print Name Relationship to Patient

Form Information Reviewed By: \_\_\_\_\_  
Print Name Signature Date/Time

MRI Technologist  Nurse  Radiologist  Other: \_\_\_\_\_

**MEMORIAL HERMANN**  
**Magnetic Resonance (MR) Procedure Screening Form For Patients**



Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Number: \_\_\_\_\_

Name: \_\_\_\_\_  
Last name First name Middle Initial

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female   
month day year

Body Part to be Examined: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone (home): (\_\_\_\_) \_\_\_\_ - \_\_\_\_

City: \_\_\_\_\_

Telephone (work): (\_\_\_\_) \_\_\_\_ - \_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Referring Physician: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?  No  Yes

If Yes, please indicate the date and type of surgery:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Type of surgery: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Type of surgery: \_\_\_\_\_

2. Have you had prior therapy for back pain?  No  Yes If yes, please specify: \_\_\_\_\_ Type \_\_\_\_\_ Date \_\_\_\_\_

3. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)?  No  Yes

If yes, please list: Body Parts Date Facility

	Body Parts	Date	Facility
MRI	_____	____/____/____	_____
CT/CAT Scan	_____	____/____/____	_____
X-Ray	_____	____/____/____	_____
Ultrasound	_____	____/____/____	_____
Nuclear Medicine	_____	____/____/____	_____
Other	_____	____/____/____	_____

4. Have you experienced any problem related to a previous MRI examination or MR procedure?  No  Yes

If yes, please describe: \_\_\_\_\_

5. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic shavers, shavings, foreign body, etc.)?  No  Yes

If yes, please describe: \_\_\_\_\_

6. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?  No  Yes

If yes, please describe: \_\_\_\_\_

7. Are you currently taking or have you recently taken any medication or drug?  No  Yes

If yes, please list: \_\_\_\_\_

8. Are you allergic to any medication?  No  Yes

If yes, please list: \_\_\_\_\_

9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast Medium or dye used for an MRI, CT, or X-ray examination?  No  Yes

10. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, diabetes, on dialysis, renal or liver transplant, or seizures?  No  Yes

If yes, please describe: \_\_\_\_\_

**For Female Patients:**

11. Date of last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_ Post menopausal?  No  Yes

12. Are you pregnant or experiencing a late menstrual period?  No  Yes

13. Are you currently breast feeding?  No  Yes

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