

# MRI SCREENING FORM



SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete  
DOS: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PATIENT #: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ / AGE: \_\_\_\_ / SEX: \_\_\_\_\_

**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. 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 room. The MR system magnet is ALWAYS ON.

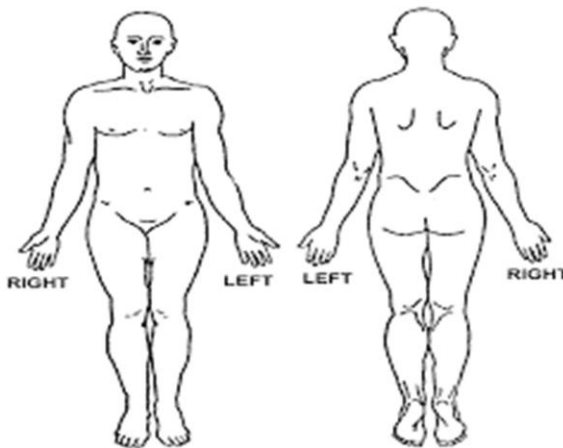
**Please indicate if you have any of the following:**

- Yes  No Aneurysm clip(s)
- Yes  No Cardiac pacemaker
- Yes  No Implanted cardioverter defibrillator (ICD)
- Yes  No Electronic implant or device
- Yes  No Magnetically-activated implant or device
- Yes  No Neurostimulator or bone stimulator
- Yes  No Brace, splint or other joint support
- Yes  No Internal electrodes or residual wires
- Yes  No Cochlear, otologic, or other ear implant
- Yes  No Insulin or other infusion pump
- Yes  No Morphine infusion pump
- Yes  No Penile prosthesis
- Yes  No Heart valve prosthesis
- Yes  No History of eye or retina surgery
- Yes  No Artificial or prosthetic limb
- Yes  No Abdominal aortic aneurysm stent graft
- Yes  No Shunt (spinal or intraventricular)
- Yes  No Radiation seeds or implants
- Yes  No Medication patch (Nicotine, Nitroglycerin)
- Yes  No Any metallic fragment or foreign body
- Yes  No Wire mesh implant
- Yes  No Breast tissue expander
- Yes  No Surgical staples, clips, or metallic sutures
- Yes  No Joint replacement (hip, knee, etc.)
- Yes  No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes  No IUD
- Yes  No Dentures or partial plates
- Yes  No Body piercing jewelry
- Yes  No Hearing aid (Remove before entering)
- Yes  No Breathing problem or motion disorder
- Yes  No Claustrophobia (Afraid of confined spaces)
- Yes  No **Have you ever been injured by any metallic object (e.g. bullet, shrapnel, BB, etc.)?**
- Yes  No **Have you ever had an eye injury involving a metallic object (e.g. metallic slivers, shavings, etc.)?**

## IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove ALL metallic objects including cell phones, **ALL JEWELRY**, hearing aids, dentures, partial plates, keys, eyeglasses, hair pins, barrettes, body piercings, watches, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools. Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE YOU ENTER THE MRI SYSTEM ROOM. Lockers will be provided before entering the MRI Suite (Glasses, dental work, shoes can remain with you until you enter the room). **For your safety, you will be asked to change into a gown.**

PLEASE MARK ON THE FIGURE BELOW THE LOCATION OF IMPLANTS OR METAL INSIDE OF OR ON YOUR BODY



Note: You may be advised to wear earplugs or other hearing protection during the MRI to prevent possible problems related to noise. MRI is generally a safe procedure. Qualified medical personnel will be present throughout procedure.

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

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

If Form Completed By Someone Other than the Patient (Print name/Relationship): \_\_\_\_\_

MRI Technologist: \_\_\_\_\_

# MRI CONTRAST FORM



SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete  
DOS: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PATIENT #: \_\_\_\_\_  
PATIENT NAME: \_\_\_\_\_  
DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ / AGE: \_\_\_\_ / SEX: \_\_\_\_

Your doctor has asked that your symptoms be evaluated with an MRI study with gadolinium intravenous contrast. Gadolinium contrast is given by injection into a vein and helps provide the radiologist with additional information that may not be available without intravenous contrast.

The gadolinium contrast agent you will receive has been approved as safe and effective by the U.S. Food and Drug Administration (FDA). As with any medication, a small chance exists that you may have a reaction to it. Minor and temporary reactions include pain at the injection site, nausea, headache, dizziness, itching, rash or hives. Rarely, a more serious allergic reaction may occur (including facial swelling, difficulty breathing, or low blood pressure) requiring treatment. The odds of an extremely severe reaction, including death, are very rare.

Your chances of a reaction may be increased if you have had a previous allergic reaction to gadolinium, are allergic to other drugs or foods, have asthma, or suffer from kidney disease. Please inform the MR technologist if any of these situations apply to you.

### Please answer the questions below.

Please list all allergies: \_\_\_\_\_  
 Yes  No - Do you have asthma?  
 Yes  No - Do you have an allergy to CT (iodinated contrast) or MRI (gadolinium) contrast? (If yes, circle which one)  
If yes, when and what happened? \_\_\_\_\_  
 Yes  No - Have you ever had an anaphylactic reaction (severe allergic reaction where you had to be hospitalized)?  
If yes, when and what happened? \_\_\_\_\_

**FOR WOMEN:** Are you breast feeding?  Yes  No

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. By signing below you agree to gadolinium contrast injection.

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

If Form Completed By Someone Other than the Patient (Print name): \_\_\_\_\_

Relationship: \_\_\_\_\_

TECHNOLOGIST USE ONLY

IV Contrast: \_\_\_\_\_ cc (Circle) Dotarem Multihance Other: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_ MRI Technologist: \_\_\_\_\_

# MRI CHEST HISTORY



SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete  
DOS: \_\_\_ / \_\_\_ / \_\_\_

PATIENT #: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_ / AGE: \_\_\_ / SEX: \_\_\_\_\_

**\*\*\* Please answer the following questions about your medical history to the best of your ability. Our Radiologists and staff will use the information you provide to select the most appropriate imaging techniques and to interpret the examination in order to best serve you! If you have any questions, please do not hesitate to ask. \*\*\***

What is the diagnosis code or reason listed on your script? \_\_\_\_\_

**Why** are you having this test? \_\_\_\_\_

**Describe** your symptoms: \_\_\_\_\_

**How long** have you had these symptoms (problems)? \_\_\_\_\_

Yes  No - Are you a current smoker?

Yes  No - Did you smoke in the past? If you quit, how long ago? \_\_\_\_\_

Yes  No - Have you ever had the following (please circle): COPD, emphysema, asthma, heart disease, aneurysm of the aorta, reflux or GERD (gastroesophageal reflux disease), hepatitis or liver disease, gallbladder disease or gallstones, pancreatitis, kidney stones, bowel obstruction, Crohn's disease, diverticulitis, colitis, endometriosis, fibroids, hernia.

Yes  No - Have you ever had surgery on the part of your body being imaged?

Yes  No - Have you had surgery of the lungs, heart, other?

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

Yes  No - Do you have a personal history of lung cancer? If yes, right lung or left lung? (Please circle)

Yes  No - Do you have a personal history of other cancer? If yes, what type and when was it diagnosed?

If yes, describe how your cancer was treated (radiation/gamma knife/proton/chemo/surgery)? Please list approx. dates of treatment/procedures: \_\_\_\_\_

Please list what/when/where you've had prior studies of this body part (MRI/CT/XRays/US/Angio/Nuclear Med)?

<b>FOR WOMEN:</b> Date of last menstrual period: _____	Are you post menopausal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you experiencing a late menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any chance that you are pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you taking any form of birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	-- If yes, list: _____

<b>TECHNOLOGIST USE ONLY</b>	
Comments: _____	
_____	
_____	
MRI Technologist: _____	Ext: _____

I attest that the information on the form above, including technologist comments above 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 MR procedure that I am about to undergo.

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

If Form Completed by Someone Other than the Patient (Print name): \_\_\_\_\_

Relationship: \_\_\_\_\_