ADAMS COUNTY
REGIONAL MEDICAL CENTER
230 Medical Center Dr.
Seaman, Ohio 45679

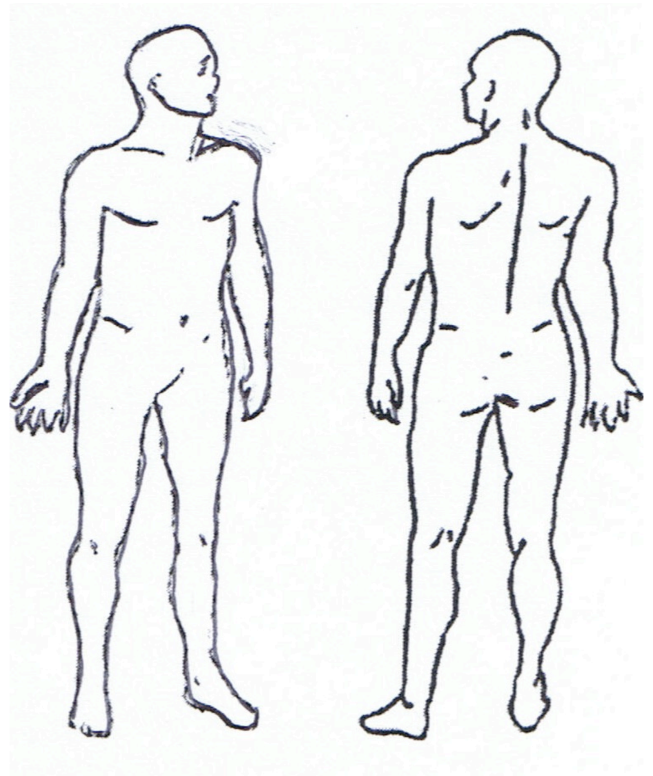
Patient Sticker

MRI SCREENING FORM

THE FOLLOWING ITEMS MAY BE HAZARDOUS OR INTERFERE WITH MRI EXAMINATIONS

Please indicate if you have the following items:

Yes	No	
[ ]	[ ]	Cardiac pacemaker
[ ]	[ ]	Aneurysm clip(s)
[ ]	[ ]	Implanted cardiac defibrillator
[ ]	[ ]	Neurostimulator
[ ]	[ ]	Any type of internal electrode(s) including:
[ ]	[ ]	Pacing wires
[ ]	[ ]	Cochlear implant
[ ]	[ ]	Other:________________________________
[ ]	[ ]	Implanted Insulin Pump
[ ]	[ ]	Swan-Ganz catheter
[ ]	[ ]	Halo vest or metallic cervical fixation device
[ ]	[ ]	Hearing Aid
[ ]	[ ]	Implanted drug infusion device
[ ]	[ ]	Any type of foreign body, shrapnel, or bullet
[ ]	[ ]	Heart valve prothesis
[ ]	[ ]	Any type of ear implant
[ ]	[ ]	Penile implant
[ ]	[ ]	Orbital / eye prothesis
[ ]	[ ]	Any type of implant held in place by a magnet
[ ]	[ ]	Any type of surgical clip or staple(s)
[ ]	[ ]	Vascular access port
[ ]	[ ]	Intraventricular shunt
[ ]	[ ]	Artificial limb or joint
[ ]	[ ]	Dentures
[ ]	[ ]	Diaphragm
[ ]	[ ]	IUD
[ ]	[ ]	Pessary
[ ]	[ ]	Wire mesh
[ ]	[ ]	Medication Patch
[ ]	[ ]	Any type of Biostimulator Type:____
[ ]	[ ]	Any type of electronic, mechanical, or mechanical implant Type:____
[ ]	[ ]	Any type of intravascular coil, filter or stent (e.g. Gianturso coil, Gunther IVC Filter, palmaz Stent, etc.)
[ ]	[ ]	Any implanted orthopedic item(s) (i.e. pins, rods, screws, plates, etc.) Type:__________________________________
[ ]	[ ]	Any other implanted item: Type:____
[ ]	[ ]	Tattoo



*A small percentage of patients with a tattoo have experienced transient skin irritation in association with MRI. Therefore, you must decide if this slight risk warrants your examination. You may want to discuss this matter with your referring physician.

We strongly recommend using the ear plugs or headphones we supply for your MRI examination since some patients may find the noise levels unacceptable and the noise levels may temporarily affect your hearing.

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

FAILURE TO REPORT AN IMPLANTED DEVICE COULD RESULT IN DEATH

Patient's signature :____ Date ;______________________________

MD/ RN/ RT signature :____ Date :_____________________________

Print MD/ RN/ RT name:____

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MRI SCREENING FORM

Name:____

Home Phone Number:_______-________-______ Work Phone Number:_______-______-_______

Sex:___ Age:___ Date Of Birth:_____/____/____ Height:______ Weight:_______ Patient #________

Diagnosis:____

Clinical History:____

____

	Yes	No
Have you ever had a surgical procedure or operation of any kind?.......................................	( )	( )
If yes, please list all prior surgeries and approximate dates:__________________________________		
Have you ever been injured by any metallic foreign body (e.g bullet, BB, shrapnel, etc.)?.....	( )	( )
Please describe:____		
Have you ever had an injury to the eye involving a metallic object (e.g. metallic slivers, shavings, foreign body, etc.)?..	( )	( )
Please describe: ____		
Do you have anemia or diseases that affect your blood?...	( )	( )
Do you have a history of renal disease, seizure, asthma or allergic respiratory disease?.........	( )	( )
Do you have drug allergies?...	( )	( )
If yes, please list____		
Have you ever had a reaction to contrast medium used in MRI or CT?.................................	( )	( )
Are you pregnant or do you suspect that you are pregnant?...	( )	( )
Are you breast feeding?..	( )	( )
Last menstrual period:___________________________ Post menopausal?............................	( )	( )
Are you taking oral contraceptives or receiving hormone treatment?.......................................	( )	( )