

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

- 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 _____
- 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 _____
- Do you have a personal history of cancer? Yes No
If Yes, what type: _____
- Are you allergic to any medications/ drugs? Yes No
If Yes, please list: _____
- 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: _____
- Do you have asthma, seasonal allergies, allergic reactions or respiratory disease? Yes No
If Yes, please explain: _____
- Do you have claustrophobia or anxiety regarding your MRI examination? Yes No
If Yes, please explain: _____
- Are you taking any medication to help you through the exam due to claustrophobia? Yes No
If Yes, please list: _____
- Will you be able to lie flat for at least 45 minutes? Yes No
- Do you have breast implants? Yes No
If Yes, Saline Silicone

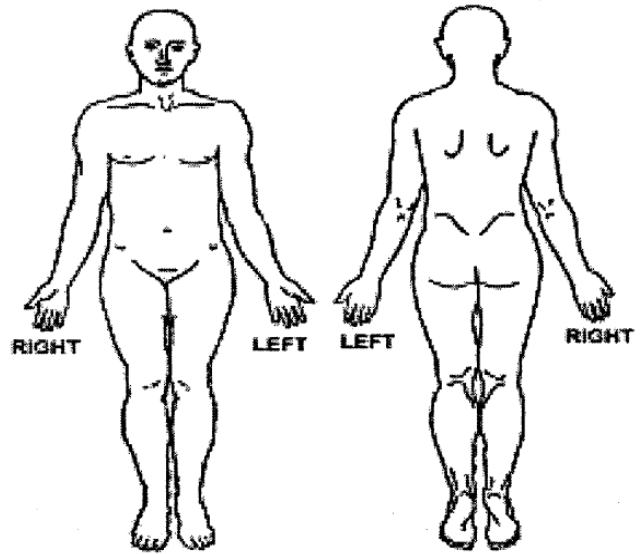
For female patients:

- Date of last menstrual period: ____ / ____ / ____ Peri-menopausal Post-menopausal
- Are you pregnant or is there any chance that you could be pregnant? Yes No
- Are you experiencing a late menstrual period? Yes No
- Are you currently breast-feeding? Yes No
- Do you have an IUD, Diaphragm or Pessary? Yes No
If Yes, what type: _____
- 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