BIOMEDICAL IMAGING CENTER
OSU Medicine

Rev 20220715

MRI SCREENING FORM

First Name: _____ M.I.:_____ Last Name:_____

DOB:_____ Male / Female Height: _____ Weight:_____ Last 4 of SS#: _____

MRI ordered today: _____ Physician _____

Have you had prior imaging on the body part we are imaging today? When/where?:_____

Have you ever had surgery on the body part we are imaging today? If Yes, when?:_____

Are you here today due to a **SPECIFIC INJURY**? If yes, what kind of injury and when?_____

Describe your symptoms_____

List ANY Allergies:_____

WARNING: Certain implants, devices or objects may be hazardous to your safety, and may interfere with your MRI. Please answer the questions as accurately as possible.

O YES O NO Aneurysm clip	O YES O NO Radiation seeds or implants
O YES O NO Cardiac pacemaker	O YES O NO Hypertension (high blood pressure)
O YES O NO Implanted Cardiac Defibrillator (ICD)	O YES O NO Diabetes
O YES O NO Cardiac stents or any stents in your body	O YES O NO Multiple sclerosis
O YES O NO Artificial heart valves	O YES O NO Seizures
O YES O NO PICC line, port, shunt or Swan-Ganz catheter	O YES O NO Breathing problems (asthma, etc.)
O YES O NO Implanted electronic device	O YES O NO O MAYBE O UNKNOWN Are you claustrophobic?
O YES O NO Implanted magnetically activated device	O YES O NO Hearing aid (**REMOVE BEFORE MRI**)
O YES O NO Internal electrodes or wires of **ANY** kind	O YES O NO Cochlear implant or **ANY** ear implant
O YES O NO Tens unit (external stimulator)	O YES O NO Eyelid spring or wire
O YES O NO Spinal cord (nerve) stimulator	O YES O NO Do you have metal in your eyes?
O YES O NO Bone growth/bone fusion stimulator	O YES O NO Have you ever had metal removed from your eyes?
O YES O NO Tissue expander (prior to breast implant)	O YES O NO Have you ever had an injury to your eyes involving metal?
O YES O NO Surgical staples, clips, metal sutures	O YES O NO Injury by metal fragment (bullet, BB, shrapnel)
O YES O NO Bone /joint pins, screws, wires, plates	O YES O NO Prosthesis (eye, penile, etc.) or artificial limbs
O YES O NO Wire or mesh implants of any kind	O YES O NO Joint replacements (knee, hip, shoulder)
O YES O NO Insulin pump, pain pump, drug infusion pump	O YES O NO ANY organ transplant (heart, lung, kidneys)
O YES O NO Glucose monitor	O YES O NO Wig, hair implants, clips, or pins
O YES O NO **ANY** medication patch (Exp: pain/nicotine/nitroglycerin)	O YES O NO Body piercings
O YES O NO Are you taking any medication or drug?	O YES O NO Tattoo/permanent makeup
O YES O NO Have you taken oral sedation for this MRI?	O YES O NO Post-menopausal?
O YES O NO Are you under the care of a nephrologist?	O YES O NO Are you taking oral contraceptives or hormone treatment?
O YES O NO Kidney or liver disease, kidney failure, or on dialysis	O YES O NO IUD, diaphragm, pessary
O YES O NO Blood disorder (anemia, leukemia, sickle cell)	O YES O NO Birth control patches
O YES O NO Are you currently breastfeeding?	O YES O NO O MAYBE **Are You Pregnant**?
O YES O NO Allergic reaction to MRI contrast medium/"dye"	(Circle all that apply) Dentures / partials / retainers / braces

O YES O NO Do you have a history of metal work (e.g., grinding, welding)? If YES, when? _____

O YES O NO Do you have a history of cancer in **YOUR** body? If YES, what kind and when_____

O YES O NO Do you have metallic cosmetics in or on your body, including magnetic eye lashes, hair weaves, etc.? If YES, what kind and where are they located ? _____

O YES O NO DO YOU HAVE ANY OTHER METAL IN YOUR BODY? If yes , where?_____

WARNING: The MRI system magnet is ALWAYS on. Please consult the MRI technologists if you have any questions or concerns BEFORE entering the MRI system room. Before entering the MR environment, you will also be required to remove all metallic objects, including but not limited to, hearing aids, partial plates, billfold, pocket knife, keys, check/credit cards, cellphone, glasses, any metal in your hair, all body piercings, watch, bracelets, coins, pens, bras, and firearms. Zinc oxide-based creams (often found in sunscreen) should be avoided to reduce risks of burns.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form. I have 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: _____

O Self O Spouse O Guardian O Other

Technologist who reviewed screening with patient:_____ Date:_____