



DIAGNOSTIC IMAGING
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**MAGNETIC RESONANCE (MR)
 PROCEDURE SCREENING FORM**

MRN # _____
 MALE _____ FEMALE _____

Patient Name: _____ Date of Birth: ____/____/____
 (Last and Suffix, i.e. Jr.,Sr.) (First) (MI)

Please Answer Yes or No if you have any of the following:

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: _____

- | | |
|---|---|
| Yes ____ No ____ Diabetic | Yes ____ No ____ Vascular access port and/or catheter |
| Yes ____ No ____ Aneurysm clip(s) | Yes ____ No ____ Radiation seeds or implants |
| Yes ____ No ____ Implanted cardioverter defibrillator (ICD) | Yes ____ No ____ Swan-Ganz or thermodilution catheter |
| Yes ____ No ____ Electronic implant or device | Yes ____ No ____ Medication patch (Nicotine, Nitro-Glycerine) |
| Yes ____ No ____ Magnetically-activated implant or device | Yes ____ No ____ Any metallic fragment or foreign body |
| Yes ____ No ____ Neurostimulation system | Yes ____ No ____ Wire mesh implant |
| Yes ____ No ____ Spinal cord stimulator | Yes ____ No ____ Tissue expander (e.g., breast) |
| Yes ____ No ____ Internal electrodes or wires | Yes ____ No ____ Surgical staples, clips, or metallic sutures |
| Yes ____ No ____ Bone growth/bone fusion stimulator | Yes ____ No ____ Joint replacement (hip, knee, etc.) |
| Yes ____ No ____ Cochlear, otologic, or other ear implant | Yes ____ No ____ Bone/joint pin, screw, nail, wire, plate |
| Yes ____ No ____ Insulin or other infusion pump | Yes ____ No ____ IUD, diaphragm, or pessary |
| Yes ____ No ____ Implanted drug infusion device | Yes ____ No ____ Dentures or partial plates |
| Yes ____ No ____ Any type of prosthesis (eye, penile, etc.) | Yes ____ No ____ Tattoo or permanent makeup |
| Yes ____ No ____ Heart valve prosthesis | Yes ____ No ____ Body piercing jewelry |
| Yes ____ No ____ Eyelid spring or wire | Yes ____ No ____ Hearing aid-Remove before entering MR room |
| Yes ____ No ____ Artificial or prosthetic limb | Yes ____ No ____ Breathing problem or motion disorder |
| Yes ____ No ____ Metallic stent, filter, or coil | Yes ____ No ____ Other Implant _____ |
| Yes ____ No ____ Shunt (spinal or intraventricular) | Yes ____ No ____ Claustrophobia |

- Have you experienced any problem related to previous MRI examinations or procedures? No ____ Yes ____
 If so, describe: _____
- Have you had an injury to the eye involving a metallic object or fragment (e.g. metallic slivers, shavings, foreign body, etc.)? No ____ Yes ____
 If so, describe: _____
- Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel, etc.)? No ____ Yes ____
 If so, describe: _____
- Are you currently taking or have you recently taken any medication or drug? No ____ Yes ____
 If so, explain: _____
- Are you allergic to any medication? No ____ Yes ____
 If so, describe: _____
- 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 ____
 If so, describe: _____

For Female patients:

- Are you pregnant or experiencing a late menstrual period? No ____ Yes ____
 Date of last menstrual period: ____/____/____
 Are you currently breastfeeding? No ____ Yes ____

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.

Signature of the Person Completing Form: _____ Date ____/____/____
 Signature

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 question or concern 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.**