Children's Memorial Hospital
Department of Medical Imaging

PATIENT MRI SCREENING FORM

Place Patient Sticker Here		Do you have allergies: ☐ YES ☐ NO If yes, please list:
		Have you had previous MRI Studies: ☐ YES ☐ NO If yes, please list:
Weight:	Height:	Last Menstrual Period Date:

The following items can interfere with MR imaging and some can actually be hazardous to your safety. Please check if you have any of these items:

YES	NO	
☐	☐	Insulin or Infusion Pump
☐	☐	Cardiac pacemaker/pacemaker lead wires
☐	☐	Brain aneurysm clips
☐	☐	Aortic clips
☐	☐	Implanted neurostimulators or lead wires
☐	☐	Artificial heart valve
☐	☐	Insulin pump/implanted drug pump
☐	☐	External Fixation Devices
☐	☐	Coils/Stents/Filters
☐	☐	IUD/Diaphragm
☐	☐	VP or Programmable Shunt
☐	☐	Joint replacements/Prosthesis
☐	☐	Fractured bones treated with metal rods, metal plates, pins, screws, nails or clips
☐	☐	Spinal Harrington rods
☐	☐	Prosthesis (Eye, Penile, Joint)
☐	☐	Eye Implants/Eyelid Springs
☐	☐	Spinal Fusion Pump/Spinal Cord Stimulator
☐	☐	Wire Sutures/Staples/Clips
☐	☐	Shrapnel/bullets/BB's
☐	☐	Dentures/Braces/Retainers
☐	☐	Metal slivers or foreign body in the eyes
☐	☐	Cochlear implants/Ear implants
☐	☐	Tattoo or Tattoo eyeliner
☐	☐	ICD Implanted Cardioverter Defibrillator
☐	☐	Urinary or Temperature Foley

MRI Contrast Form MUST be filled out by patient or parent/legal guardian. Once form is filled out it MUST be discussed MRI Nurse or MRI Tech

YES	NO	
☐	☐	Trachea/Endotracheal Tubes
☐	☐	Electrodes/Medication Patches
☐	☐	Bivona Trachea
☐	☐	Swan-Ganz Catheter
☐	☐	Port-A-Cath
☐	☐	Tissue Expanders
☐	☐	
☐	☐	

MRI Contrast First Dose Review

☐ YES ☐ NO RN____________

Medication Reconciliation Form

☐ YES ☐ NO RN____________

Please list all Surgeries and Dates:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________

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.

Patient/Legal Guardian Signature______________________________Relationship to Patient_______________
MD, RT, RN____ DATE_____________________
Print name of MD, RT, RN______________________________
Revised on 7/6/07 KLR