MOLECULAR
imaging of wood dale

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____/_____/_____ Patient # ______________________

Name ____ Age ______ Height ________ Weight _______
Last First Middle

Body Part to be Examined ____________________________ DOB: ______/______/______ Male ☐ Female ☐
mm dd yy

Address ____ Telephone (H) (_____) ________ - __________

City ___________________State_____ Zip Code________ Telephone (W) (_____)________ - ___________

Referring Physician _________________________________ Telephone (_____) ___________ - __________

Please indicate if you have any of the following:

☐ No ☐ Yes Brain Aneurysm clip(s)
☐ No ☐ Yes Cardiac pacemaker
☐ No ☐ Yes Injury to the eye involving metal
☐ No ☐ Yes Metal removed from eye by doctor
☐ No ☐ Yes Are you a welder or machinist
☐ No ☐ Yes Internal electrodes or wires
☐ No ☐ Yes Bone growth/bone fusion stimulator
☐ No ☐ Yes Cochlear, otologic, or other ear implant
☐ No ☐ Yes Insulin or other infusion pump
☐ No ☐ Yes Tissue expander
☐ No ☐ Yes Implanted drug infusion device
☐ No ☐ Yes Prosthesis (eye, penile, etc.)
☐ No ☐ Yes False teeth, retainers, or magnetic braces
☐ No ☐ Yes Surgical clips, staples, wires, mesh, or stitches
☐ No ☐ Yes Heart valve prosthesis
☐ No ☐ Yes Spinal cord stimulator
☐ No ☐ Yes Eye Implant, Eyelid spring or wire
☐ No ☐ Yes Artificial or prosthetic limb/joint
☐ No ☐ Yes Metallic stent, filter, or coil in blood vessel

☐ No ☐ Yes Dentures or partial plates
☐ No ☐ Yes Tattoo or permanent makeup
☐ No ☐ Yes Body piercing jewelry
☐ No ☐ Yes Magnetically activated implant or device
☐ No ☐ Yes Neurostimulation system
☐ No ☐ Yes Hearing aid *(**Remove Before Exam**)*
☐ No ☐ Yes Claustrophobia
☐ No ☐ Yes Shunt (spinal or intraventricular)
☐ No ☐ Yes Vascular access port and/or catheter/tube
☐ No ☐ Yes Electrical stimulator for nerves or bones
☐ No ☐ Yes Radiation seeds or implants
☐ No ☐ Yes Swan-Ganz or thermodilution catheter
☐ No ☐ Yes Medication patch (Nicotine, Nitroglycerine)
☐ No ☐ Yes Metal shrapnel, fragments or foreign body
☐ No ☐ Yes Bullets, BBs, or pellets
☐ No ☐ Yes Wire mesh implant
☐ No ☐ Yes Surgical staples, clips, or metallic sutures
☐ No ☐ Yes Joint replacement (hip, knee, etc.)
☐ No ☐ Yes Bone/joint pin, screw, nail, wire, plate, etc.

For Female Patients:

9. Date of last menstrual period:_____/_____/_____ Post menopausal? ☐ No ☐ Yes
10. Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes
14. Do you have an IUD? ☐ 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.

Patient/Parent/Legal Guardian Signature:______________________________________ Date _____/_____/_____

Form Information Reviewed By: ____ MRI Technologist

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure.
If you have any question or concern regarding an implant, device, or object,
Consult the MRI Technologist BEFORE entering the MR system room.
The MR system magnet is ALWAYS on. DO NOT ENTER!!!