REAGAN DIAGNOSTICS

2878 Five Forks Trickum Rd, Suite 1A, Lawrenceville, GA 30044

Direct Line: 678-221-8000 Direct Fax Orders: 678-387-2300

MRI SCREENING FORM

Patient's name: _____ Date: _____

Address: _____

DOB: _____ Age: _____ Height: _____Weight: _____ Sex: □ Male □ Female

Email address: _____Mobile phone: _____

Reason for MRI / Symptoms: _____Body Part to be tested: _____

Referring Physician: _____ Telephone: _____

1.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:

Date ____/ ____/ _____ Type of Surgery _____

Date ____/ ____/ _____ Type of Surgery _____

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ❑ No ❑ Yes

If yes, please list:	Body Part	Date	Facility
MRI	_____	____/ ____/_____	_____
CAT Scan	_____	____/ ____/_____	_____
X-ray	_____	____/ ____/_____	_____
Ultrasound	_____	____/ ____/_____	_____
Nuclear Medicine	_____	____/ ____/_____	_____
Other	_____	____/ ____/_____	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ❑ No ❑ Yes
If yes, please describe: _____

4. 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 yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ❑ No ❑ Yes
If yes, please describe: _____

6. Are you currently taking or have you recently taken any medication or drug? ❑ No ❑ Yes
If yes, please list: _____

7. Are you allergic to any medication? ❑ No ❑ Yes
If yes, please list: _____

8. 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

9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? ❑ No ❑ Yes
If yes, please describe:

For female patients:

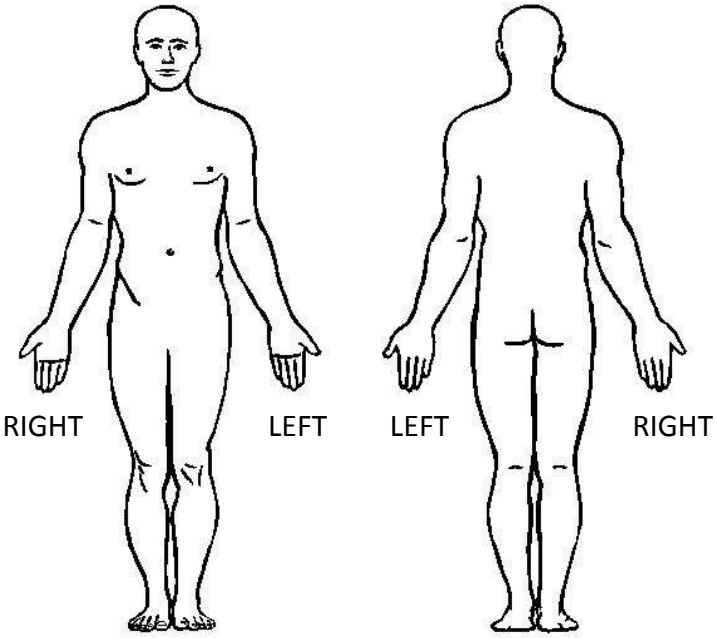
10. Date of last menstrual period: / / Post menopausal? ❑ No ❑ Yes
11. Are you pregnant or experiencing a late menstrual period? ❑ No ❑ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ❑ No ❑ Yes
13. Are you taking any type of fertility medication or having fertility treatments? ❑ No ❑ Yes
If yes, please describe: _____
14. Are you currently breastfeeding? ❑ No ❑ Yes

WARIZNG: 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.

please indicate if you have any of the following:

- ❑ No ❑ Yes Aneurysm clip(s)
- ❑ No ❑ Yes Cardiac pacemaker
- ❑ No ❑ Yes Implanted cardioverter defibrillator (ICD)
- ❑ No ❑ Yes Electronic implant or device
- ❑ No ❑ Yes Magnetically-activated implant or device
- ❑ No ❑ Yes Neurostimulation system.
- ❑ No ❑ Yes Spinal cord stimulator
- ❑ 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 Implanted drug infusion device
- ❑ No ❑ Yes Any type of prosthesis (eye, penile, etc.)
- ❑ No ❑ Yes Heart valve prosthesis
- ❑ No ❑ Yes Eyelid spring or wire
- ❑ No ❑ Yes Artificial or prosthetic limb
- ❑ No ❑ Yes Metallic s tent, filter, or coil
- ❑ No ❑ Yes Shunt (spinal or intraventricular)
- ❑ No ❑ Yes Vascular access port and/or catheter
- ❑ No ❑ Yes Radiation seeds or implants
- ❑ No ❑ Yes Swan-Ganz or thermodilution catheter
- ❑ No ❑ Yes Medication patch (Nicotine, Nitroglycerine)
- ❑ No ❑ Yes Any metallic fragment or foreign body
- ❑ No ❑ Yes Wire mesh implant
- ❑ No ❑ Yes Tissue expander (e.g., breast)
- ❑ 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.
- ❑ No ❑ Yes IUD, diaphragm, or pessary
- ❑ No ❑ Yes Dentures or partial plates
- ❑ No ❑ Yes Tattoo or permanent makeup
- ❑ No ❑ Yes Body piercing jewelry
- ❑ No ❑ Yes Hearing aid *(Remove before entering MR system room)*
- ❑ No ❑ Yes Other implant _____
- ❑ No ❑ Yes Breathing problem or motion disorder
- ❑ No ❑ Yes claustrophobia

Please mark on the figures(s) below the location of any implant or metal inside of or on your body



IMPORTANT INSTRUCTIONS

Before entering the MER environment or MR 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 jewelry, watch, safety pins, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, &clothing with metallic threads.

Please consult the MIRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

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 Person Completing Form: _____Date: ____/ ____/ _____

Form Completed By: .❑ Patient ❑ Relative ❑ Nurse: (Name) _____ Relationship: _____

Form information reviewed by: (Name): _____ Signature: _____