Baton Rouge General
A Community of Caring

Patient Label

Magnetic Resonance (MR)
Screening Form and Contrast Questionnaire

Weight: ____________ Body part to be Examined: ____

Reason for MRI and/or Symptoms ____

____

Pregnant? q Yes q No q N/A Date of last menstrual period: _______ /______/__________ q N/A

Breastfeeding? q Yes q No q N/A

1. Have you had any prior surgeries? q Yes q No

   If yes, please indicate the date and type of surgery:

   ____

   ____

   ____

2. Have you had a prior diagnostic imaging study or exam on the body part we are imaging today? q Yes q No

   If yes, please list: type of scan (MRI, CT, X-Ray, Ultrasound, Nuclear Medicine, other), date, and facility where you had the test:

   ____

   ____

   ____

   ____

3. Have you ever had:
   - q Yes q No Metal in your eyes?
   - q Yes q No Head or brain surgery?

4. Have you ever done any:
   - q Yes q No Welding?
   - q Yes q No Grinding?
   - q Yes q No Machine work?
   - q Yes q No Metal Lathe work?

5. Have you ever had any of the following:
   - q Yes q No Asthma?
   - q Yes q No Sickle cell disease?
   - q Yes q No Cardiac Disease?
   - q Yes q No Diabetes?
   - q Yes q No Kidney problems or disease?
   - q Yes q No Kidney transplant?
   - q Yes q No High blood pressure?
   - q Yes q No An allergic reaction to Contrast media? If yes, please describe: ______________________________
   - q Yes q No Cancer? If yes, please describe: ______________________________
   - q Yes q No Allergic to any medications? If yes, please describe: ______________________________

Important Instructions

Before entering the MR 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, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, body piercings/jewelry, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any questions 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 information on this form is correct to the best of my knowledge. I have read and understand the entire contents of this form and 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: ______/_____ /________ Time: ___________

Completed by: q Patient q Relative q Nurse Print name: ________________________________ Relationship: _________________

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Magnetic Resonance (MR)
Procedure Screening Form for Patients

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.

Please indicate if you have any of the following:

q Yes q No Aneurism clip(s)
q Yes q No Cardiac pacemaker
q Yes q No Implanted cardioverter defibrillator (ICD)
q Yes q No Electronic implant or device
q Yes q No Magnetically-activated implant or device
q Yes q No Neurostimulation system
q Yes q No Spinal cord stimulator
q Yes q No Internal and/or External electrodes or wires
q Yes q No Bone growth/bone fusion stimulator
q Yes q No Cochlear, otologic, or other ear implant
q Yes q No Insulin or other infusion pump
q Yes q No Implanted drug infusion device
q Yes q No Any type of prosthesis (eye, penile, etc.)
q Yes q No Heart valve prosthesis
q Yes q No Eyelid spring or wire
q Yes q No Artificial or prosthetic limb
q Yes q No Metallic stent, filter, or coil
q Yes q No Shunt (spinal or intraventricular)

q Yes q No Vascular access port and/or catheter
q Yes q No Radiation seeds or implants
q Yes q No Swan-Ganz or thermodilution catheter
q Yes q No Medication patch (Nicotine, Nitroglycerine)
q Yes q No Any metallic fragment or foreign body
q Yes q No Wire mesh implant
q Yes q No Tissue expander (e.g., breast)
q Yes q No Surgical staples, clips, or metallic sutures
q Yes q No Joint replacement (hip, knee, etc.)
q Yes q No Bone/joint pin, screw, nail, wire, plate, etc.
q Yes q No IUD, diaphragm, or pessary
q Yes q No Dentures or partial plates
q Yes q No Tattoo or permanent makeup
q Yes q No Body piercing jewelry
q Yes q No Hearing aid (remove before entering MRI room)
q Yes q No Other implant: ____________________________
q Yes q No Breathing problem or motion disorder

❑ I have received a contrast medication guideline and have had the opportunity to ask any questions I may have.

--For Technologist use only--

Patient Education
Patient was educated about the exam (pre-procedure): q Yes q No
Patient verbalized understanding: q Yes q No
Patient was educated about post-procedure instructions, if applicable q Yes q No
Patient verbalized understanding: q Yes q No

q **Yes** q **No** Patient was screened using wand
q **Yes** q **No** Patient was offered hearing protection

Form information reviewed by: Print name: ____________________________________ Signature: _____________________________________

q MRI Technologist q Nurse q Radiologist q Other: __________________________________ Time: ________

IV CONTRAST ADMINISTRATION RECORD

Contrast used: ___________________________ Expiration Date: _________________ Lot #: __________________

Volume administered: __________ ml IV / Heparin Lock/Injection Site: __________________________

Date: ______________ Injection time: ___________ Initials: ________________

If a contrast reaction occurred, was an incident report created in safety reporting system? ❑ Yes ❑ No ❑ N/A