OREGON ADVANCED IMAGING

PRE -MRI SAFETY SCREENING

EXAM DATE: _____ **EXAM:** _____

PID#:

PATIENT INFORMATION

NAME: _____ **DOB:** _____

HEIGHT: _____ **WEIGHT:** _____

AGE: _____ **SEX:** M F

ABSOLUTE CONTRAINDICATIONS:

Swan-Ganz Catheter	☐ Yes	☐ No
Breast Tissue Expander	☐ Yes	☐ No

CONDITIONS THAT REQUIRE FURTHER INFO:

Cardiac Pacemaker or Cardiac Defibrillator	☐ Yes	☐ No
Spinal Cord Stimulator or Neurostimulator	☐ Yes	☐ No
Bladder Stimulator	☐ Yes	☐ No
Cochlear, Otologic, or Ear Implant	☐ Yes	☐ No
Deep Brain Stimulator	☐ Yes	☐ No
Aneurysm Clip(s)	☐ Yes	☐ No
Carotid Artery Vascular Clamp	☐ Yes	☐ No
Bone Growth/Fusion Stimulator	☐ Yes	☐ No
Artificial Joint or Limb	☐ Yes	☐ No
Any Prosthesis/Implants (Eye, Penile, Breast)	☐ Yes	☐ No
Intravascular Stents, Filters, or Coils	☐ Yes	☐ No
Shunt (Spinal or Intraventricular)	☐ Yes	☐ No
Insulin/Diabetes Pump or Device	☐ Yes	☐ No
Heart Valve Prosthesis/Internal Pacing Wires	☐ Yes	☐ No
Aortic Clip/Wire Sutures/Surgical Staples	☐ Yes	☐ No
Any Metal Fragments or Piercing(s)	☐ Yes	☐ No
Harrington/Metal Rods, Screw in Bones	☐ Yes	☐ No
Pain Pump	☐ Yes	☐ No

ASSESSMENT/ MODIFICATION CONSIDERATIONS:

Electrodes (on Body, Head, or Brain)	☐ Yes	☐ No
Tattooed Makeup (Eyeliner, lips, etc.)	☐ Yes	☐ No
Medication/Transdermal Patch (Nitro, etc.)	☐ Yes	☐ No
IUD/Diaphragm/Pessary	☐ Yes	☐ No
Dentures/Hearing Aid (remove before MRI)	☐ Yes	☐ No
Claustrophobic	☐ Yes	☐ No

HEALTH HISTORY:

MRSA (Infectious Disease)	☐ Yes	☐ No
Allergies – Drug / Latex / Nitrile	☐ Yes	☐ No

Allergies or Sensitivity

X-Ray/CT Contrast (Iodine)	☐ Yes	☐ No
MRI Contrast (Gadolinium)	☐ Yes	☐ No
Possible pregnancy or breast feeding?	☐ Yes	☐ No
History or current diagnosis of tumor/cancer?	☐ Yes	☐ No

If YES, where? _____ When? _____

Treatment: _____

_____

_____

History of kidney dialysis?	☐ Yes	☐ No
History of kidney failure?	☐ Yes	☐ No

FOR OFFICE USE ONLY

Previous surgeries (invasive procedures):

_____

_____

_____

_____

_____

_____

_____

_____

Form Completed by: Patient _____ Relative/Other _____

Reviewed with MRI Staff: _____

Pandora Music Choice: _____

CONSENT: To be signed at time of appointment and in the presence of MRI Staff.

The procedure(s), alternatives, and risks have been explained to my satisfaction including the possible administration of contrast media. I hereby consent to the procedure(s).

Signature or Patient/Relative/Other: _____ Patient unable to sign: _____

MRI TECHNOLOGIST: _____ DATE: _____

FOR OFFICE USE ONLY

NAME: _____ **PID#:** _____

AREA BEING IMAGED: _____

_____

_____

_____

EXACT LOCATION OF PAIN – SPECIFIC (R/L, low, lateral, medial, RUQ, etc.) _____

_____

RADIATION OF PAIN (R/L, leg(s), feet, arm(s), other areas of spine.) _____

_____

LOCATION OF NUMBNESS/TINGLING: _____

DURATION OF PAIN/SYMPTOMS – SPECIFIC: _____

PAIN AGGRAVATED BY: _____

PREVIOUS SURGERY TO BODY PART? **IF YES,** SURGERY TYPE AND DATE: _____

PREVIOUS DIAGNOSIS OF CANCER? IF YES, DETAILS (type of cancer, diagnosis date, all treatments)
DISREGARD BASAL/SQUAMOUS SKIN CANCER:

_____

INJURY? **IF YES,** SPECIFIC DETAILS (fall off bike, rollover MVC, restrained/unrestrained.) _____

_____

DATE OF INJURY: _____

ADDITIONAL INFO NEEDED FOR SPECIFIC STUDIES

ABDOMEN:

Diverticulitis/ Crohns Disease/ Diverticulosis: specify if in large or small intestine (or both)
Cholethiasis: of gallbladder, bile duct (or both) Obstruction?
Hydronephrosis: congenital or acquired? Obstruction? Infection?

BRAIN:

If CVA: specify location if known (cerebral arteries, carotid, vertebral, basiliar, cerebellar.
If hemorrhage: location of hemorrhage (brainstem, cerebellum) Acute, subacute, chronic.
Type of hemorrhage epidural, subdural, subarachnoid)

SPINE:

Specify with or without myelopathy
Previous MD diagnosis of osteoporosis or osteopenia