WINDSONG
WHERE PATIENTS COME FIRST

MRI PATIENT SCREEN

Name: ______________________ DOB: ______________ Height: ________ Weight: ________

Date: ______________ Referring Doctor: ______________________ Radiology #: ______________

Please read carefully and answer YES or NO to the following items:

Have you ever had an MRI before?	Yes	No
Are you claustrophobic?	Yes	No
Do you have allergies (including latex)?	Yes	No

If yes, what? ____

DO YOU HAVE:

- Kidney Disease (Diabetic)	Yes	No
Dialysis	Yes	No
- Insulin pump (for diabetes)	Yes	No
- Transdermal patches	Yes	No
- Cardiac pacemaker or wires from a pacemaker	Yes	No
- Vascular clips: brain*, aortic, or carotid clips	Yes	No
- Prosthetic heart valve* (other heart surgery)	Yes	No
- Metal fragments (shrapnel, gunshot wound, welding or sheet metal injury), especially metal fragments near eye*	Yes	No
- Neurostimulators (TENS Unit)	Yes	No
- Shunt (ventricular or spinal)	Yes	No
Programmable	Yes	No
- Joint replacement, artificial limb	Yes	No
- Metal plates, pins, screws, spine rod, or other metal bone devices	Yes	No

These particular items may not allow us to proceed with your examination

- Wire sutures	Yes	No
- Hickman or Broviac catheter	Yes	No
- Eye Prosthesis	Yes	No
- Intrauterine Device (IUD)	Yes	No
- Middle ear prosthesis or cochlear implant	Yes	No
- Hearing Aid	Yes	No
- Dentures or braces	Yes	No
- Personal Cancer History	Yes	No

Type of Cancer ______________________

Year Diagnosed ______________________

Treatment: Chemo Yes No

Date of last treatment ______________

Radiation Yes No

Date of last treatment ______________

PLEASE ANSWER THE FOLLOWING:

1) What body part are we imaging today? ______________
2) What are your symptoms? ______________
3) Duration of the symptoms ______________
4) Recent changes in symptoms (worsening or improvements) ______________
5) Do you have a mass in the area of concern? ______________
6) Injury to area (how long ago)? ______________
7) Have you had a steroid injection? ______________
8) Surgery to the area (what and when)? ______________
9) All previous surgeries: ______________
10) Previous tests in the past 6 months:

Test ______________ Location ______________

TECHNOLOGIST'S NOTES ONLY

Technologist Signature ______________________

Patient Signature ______________________ Date ______________

Patient Name (PRINT) ______________________________

I understand contrast material may be injected. The indications for and risks of the procedure known as an MRI were discussed with me. The risks were noted to include, but are not limited to, various types of allergic reactions to the intravenous contrast. Most of these reactions are minor, although they can be severe at times. On rare occasions, inflammation or infection at the site can occur and other more remote risks or consequences may also arise.

I have been advised that if further explanation is desired, I may ask additional questions to the staff to include any supervising radiologists and my referring physician.

______________________________ ____________

Signature of patient or legal guardian Date

______________________________ ____________

Staff witness to signature Date

FEMALE PATIENTS:

☐ I AM PREGNANT

☐ I AM NOT PREGNANT / LMP ____________

I understand and hereby release all radiologists, respective staff and the facility thereof of any and all responsibility for any adverse reaction to myself and/or damage to my unborn fetus in the event I may be pregnant.

SIGNATURE ______________________________