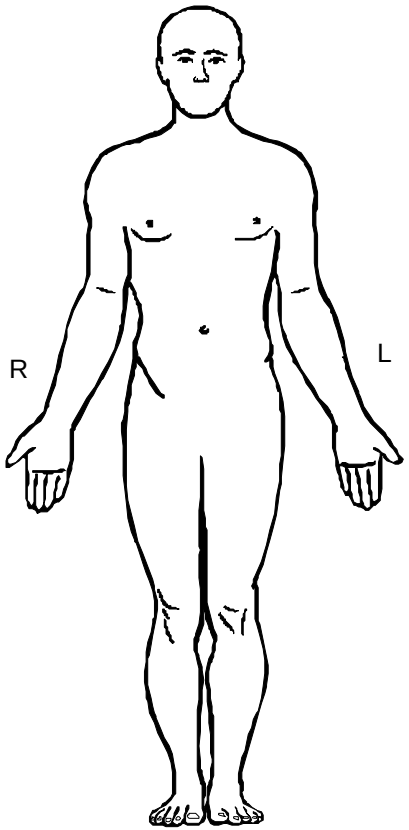
MRI SCREENING WORKSHEET

The items below can interfere with MRI and some can actually be hazardous to your safety. Please check the appropriate box next to each item. If yes, please give us a date of when you received the item.

On the drawing below, mark the approximate location of any metal.



YES	NO	
☐	☐	**Cardiac Pacemaker/Defibrillator**
☐	☐	**Aneurysm Clips: Brain Clips, AorticClips**
☐	☐	**Kidney Disease/dialysis,failure,transplant**
☐	☐	**Cochlear Implants/Stapes/Ear**
☐	☐	**Corneal Implants /Eye Implants**
☐	☐	**Neural Spine Stimulators Not Removable**
☐	☐	Heart Valve or Stents Type:_____Date:_____
☐	☐	Insulin Pump Not Removable
☐	☐	Electrodes Not Removable
☐	☐	Hearing Aids OR Dentures (Removable Yes or No)
☐	☐	Gastric Bypass (Type:_____)
☐	☐	Shunts or Stents (Type:_____)
☐	☐	Joint Replacement (Date:_____)
☐	☐	Fractures treated with Metal Rods, Metal Plates, Pins, Screws, Nails, or Clips.
☐	☐	Spine Surgery
☐	☐	Bone or Joint Pins (date:_____)
☐	☐	Prosthesis ,Artificial Limb/Joint
☐	☐	Metal Mesh, Surgical Clips, Staples
☐	☐	Wire Sutures, Metal Fragments in body
☐	☐	Shrapnel, Bullets, BB
☐	☐	Previous work w/ Metal (grinding/welding)
☐	☐	Vascular Access Ports / IV Access Ports
☐	☐	Medicated Skin Patches
☐	☐	Breast Tissue Expanders
☐	☐	Penile Implant
☐	☐	Radiation Seeds
☐	☐	Body piercings or Tattoos
☐	☐	Other (Please List)_____

Name: _____

SSN (sponsor): _____

Weight: _____ lbs. Height: _____

Today's Date: _____

Are you claustrophobic or ever had a claustrophobic reaction? Yes No

Did your doctor prescribe medication for you for claustrophobia? Yes No

If yes, you MUST have a driver with you.

Have you had surgery on the area being scanned? Yes No

Have you had **ANY** surgery in the past three months? Yes No

I hereby give authorization to GLWACH Radiology to contact me at the following number. I also consent for Radiology staff to identify themselves and/or leave a message with an answering machine or a person answering the phone in the event I am unavailable.

Home/Cell:_____

Work/Alternate:_____

Signature:_____

Radiologist's Initials:_____
Date Reviewed: _____

GENERAL LEONARD WOOD ARMY COMMUNITY HOSPITAL
RADIOLOGY DIVISION

PATIENT HISTORY FOR MRI EXAM

Patient Name: _____Last 4 SSN: _____

Women Only
Pregnant: □ Yes □ No LMP:_____ Breast Feeding: □ Yes □ No

	Circle One	
Do you have a history of Diabetes?	**Yes**	**No**
Do you have any history of Cancer?	**Yes**	**No**
Do you have a history of Kidney Disease?	**Yes**	**No**
Do you have a history of G6PD deficiency?	**Yes**	**No**
Do you have Sickle Cell anemia or other anemia issues?	**Yes**	**No**
Do you have a history of Liver disease?	**Yes**	**No**
Do you have any allergies?	**Yes**	**No**
If Yes, Please list:_____		
Do you have a history of adverse reaction to IV-MRI contrast?	**Yes**	**No**
If Yes, Please Explain:_____		

Signature of Patient_____

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(Staff use ONLY)

CONTRAST ADMINISTRATION

Agent/Brand Name: _____
Volume Injected: _____ Lot#/ Exp date: _____
GFR (if required) _____ Creatinine (if required): _____
Reaction:_____
(All adverse reactions will be annotated with a DD 4106.)

Signature of Technologist_____

PHARMACY COMMENTS

Pharmacist's initials: _____ Date checked: _____

A) A medication profile review was conducted and found no significant drug interactions or allergies associated with the use of _____ in this patient!

B) A medication profile was conducted and found the following concerns associated with the use of _____ in this patient