Appendix: Magnetic Resonance Imaging Patient and Non-Patient Screening Forms

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____/_____/_____ Patient Number ____________________

Name ____________________________________ Age _______ Height _______ Weight _______
Last name First name Middle Initial

Date of Birth _____/_____/_____ Male ❐ Female ❐ Body Part to be Examined ____________________
month day year

Address ____________________________________ Telephone (home) (_____) _____-_______

City ____________________________________ Telephone (work) (_____) _____-_______

State ____________________ Zip Code __________

Reason for MRI and/or Symptoms ____

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	__________	_____/_____/_____	__________
CT/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, 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

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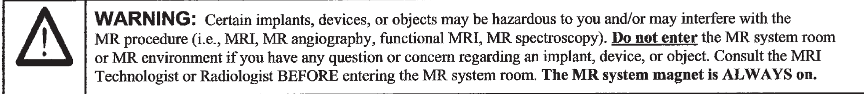
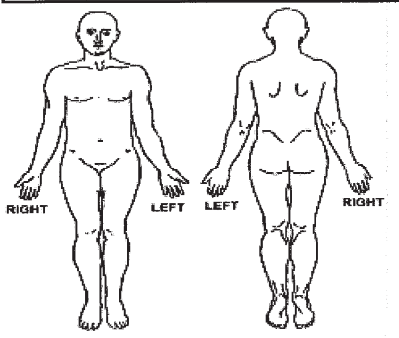


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. 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:

- ❒ Yes ❒ No Aneurysm clip(s)
- ❒ Yes ❒ No Cardiac pacemaker
- ❒ Yes ❒ No Implanted cardioverter defibrillator (ICD)
- ❒ Yes ❒ No Electronic implant or device
- ❒ Yes ❒ No Magnetically-activated implant or device
- ❒ Yes ❒ No Neurostimulation system
- ❒ Yes ❒ No Spinal cord stimulator
- ❒ Yes ❒ No Internal electrodes or wires
- ❒ Yes ❒ No Bone growth/bone fusion stimulator
- ❒ Yes ❒ No Cochlear, otologic, or other ear implant
- ❒ Yes ❒ No Insulin or other infusion pump
- ❒ Yes ❒ No Implanted drug infusion device
- ❒ Yes ❒ No Any type of prosthesis (eye, penile, etc.)
- ❒ Yes ❒ No Heart valve prosthesis
- ❒ Yes ❒ No Eyelid spring or wire
- ❒ Yes ❒ No Artificial or prosthetic limb
- ❒ Yes ❒ No Metallic stent, filter, or coil
- ❒ Yes ❒ No Shunt (spinal or intraventricular)
- ❒ Yes ❒ No Vascular access port and/or catheter
- ❒ Yes ❒ No Radiation seeds or implants
- ❒ Yes ❒ No Swan-Ganz or thermodilution catheter
- ❒ Yes ❒ No Medication patch (Nicotine, Nitroglycerine)
- ❒ Yes ❒ No Any metallic fragment or foreign body
- ❒ Yes ❒ No Wire mesh implant
- ❒ Yes ❒ No Tissue expander (e.g., breast)
- ❒ Yes ❒ No Surgical staples, clips, or metallic sutures
- ❒ Yes ❒ No Joint replacement (hip, knee, etc.)
- ❒ Yes ❒ No Bone/joint pin, screw, nail, wire, plate, etc.
- ❒ Yes ❒ No IUD, diaphragm, or pessary
- ❒ Yes ❒ No Dentures or partial plates
- ❒ Yes ❒ No Tattoo or permanent makeup
- ❒ Yes ❒ No Body piercing jewelry
- ❒ Yes ❒ No Hearing aid *(Remove before entering MR system room)*
- ❒ Yes ❒ No Other implant ____________________
- ❒ Yes ❒ No Breathing problem or motion disorder
- ❒ Yes ❒ No Claustrophobia

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



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, body piercing 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, & clothing with metallic threads.

Please consult the MRI 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 ____/____/____
Signature

Form Completed By: ❒ Patient ❒ Relative ❒ Nurse ______________________________ ______________________
Print name Relationship to patient

Form Information Reviewed By: ______________________________ ______________________
Print name Signature

❒ MRI Technologist ❒ Nurse ❒ Radiologist ❒ Other______________________

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MAGNETIC RESONANCE (MR) ENVIRONMENT SCREENING FORM FOR INDIVIDUALS*

The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. Therefore, all individuals are required to fill out this form BEFORE entering the MR environment or MR system room. **Be advised, the MR system magnet is ALWAYS on.**

***NOTE: If you are a patient preparing to undergo an MR examination, you are required to fill out a different form.**

Date ____/____/____ (month day year) Name ____________________ (Last Name First Name Middle Initial) Age ______

Address ____________________ Telephone (home) (____) ____-______

City ____________________ Telephone (work) (____) ____-______

State ____________ Zip Code ________

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ❒ No ❒ Yes
   If yes, please indicate date and type of surgery: Date ___/___/___ Type of surgery__________
2. Have you had an injury to the eye involving a metallic object (e.g., metallic slivers, foreign body)? ❒ No ❒ Yes
   If yes, please describe: ____________________
3. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ❒ No ❒ Yes
   If yes, please describe: ____________________
4. Are you pregnant or suspect that you are pregnant? ❒ No ❒ Yes

WARNING: Certain implants, devices, or objects may be hazardous to you in the MR environment or MR system room. Do not enter the MR environment or MR system room if you have any question or concern regarding an implant, device, or object.

Please indicate if you have any of the following:

❒ Yes ❒ No Aneurysm clip(s)
❒ Yes ❒ No Cardiac pacemaker
❒ Yes ❒ No Implanted cardioverter defibrillator (ICD)
❒ Yes ❒ No Electronic implant or device
❒ Yes ❒ No Magnetically-activated implant or device
❒ Yes ❒ No Neurostimulation system
❒ Yes ❒ No Spinal cord stimulator
❒ Yes ❒ No Cochlear implant or implanted hearing aid
❒ Yes ❒ No Insulin or infusion pump
❒ Yes ❒ No Implanted drug infusion device
❒ Yes ❒ No Any type of prosthesis or implant
❒ Yes ❒ No Artificial or prosthetic limb
❒ Yes ❒ No Any metallic fragment or foreign body
❒ Yes ❒ No Any external or internal metallic object
❒ Yes ❒ No Hearing aid
(Remove before entering the MR system room)
❒ Yes ❒ No Other implant____________

IMPORTANT INSTRUCTIONS

Remove all metallic objects before entering the MR environment or MR system room including hearing aids, beeper, cell phone, keys, eyeglasses, hair pins, barrettes, jewelry (including body piercing jewelry), watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, steel-toed boots/shoes, and tools. Loose metallic objects are especially prohibited in the MR system room and MR environment.

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

I attest that the above information 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.

Signature of Person Completing Form: ____________________ (Signature) Date ____/____/____

Form Information Reviewed By: ________________ (Print name) ________________ (Signature)

❒ MRI Technologist ❒ Radiologist ❒ Other ____________

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Patient Screening Form in Spanish:

CUESTIONARIO PREVIO A ESTUDIO CON RESONANCIA MAGNÉTICA (MR) PARA PACIENTES

Fecha _____/_____/_____ Número de paciente________________

Nombre_______________________________ Edad ________ Altura________ Peso_______
Apellido Primer Nombre Segundo Nombre

Fecha de nacimiento_____/_____/_____ Varón☐ Hembra☐ Parte del cuerpo a ser examinada________________
Mes Día Año

Dirección________________________________ Teléfono (domicilio) (_____) _____-__________

Ciudad________________________________ Teléfono (trabajo) (_____) _____-__________

Provincia ______________ Código Postal ________________

Motivo para el estudio de MRI y/o síntomas________________________________

Médico que le refirió ________________________ Teléfono (_____) - ________________

1. Anteriormente, ¿le han hecho alguna cirugía u operación (e.g., artroscopía, endoscopía, etc.) de cualquier tipo? ☐ No ☐ Sí
Si respondió afirmativamente, indique la fecha y que tipo de cirugía:
Fecha _____/_____/_____ Tipo de cirugía ________________________
Fecha _____/_____/_____ Tipo de cirugía ________________________
2. Anteriormente, ¿le han hecho algún estudio o exámen de diagnóstico (MRI, CT, Ultrasonido, Rayos-X, etc.)? ☐No ☐ Sí
Si respondió afirmativamente, descríbalos a continuación:

	Parte del Cuerpo	Fecha	Lugar/Institución
MRI	________	___/___/___	________
CT/CAT	________	___/___/___	________
Rayos-X	________	___/___/___	________
Ultrasonido	________	___/___/___	________
Medicina Nuclear	________	___/___/___	________
Otro________	________	___/___/___	________

3. ¿Ha tenido algún problema relacionado con estudios ó procedimientos anteriores con MR? ☐ No ☐ Sí
Si respondió afirmativamente, descríbalos: ________________________
4. ¿Se ha golpeado el ojo con un objeto ó fragmento metálico (e.g., astillas metálicas, virutas, objeto extraño, etc.)? ☐ No ☐ Sí
Si respondió afirmativamente, describa el incidente: ________________________
5. ¿Ha sido alcanzado alguna vez por un objeto metálico u objeto extraño (e.g. perdigones, bala, metralla, etc.)? ☐ No ☐ Sí
Si respondió afirmativamente, describa el incidente: ________________________
6. ¿Esta actualmente tomando ó ha recientemente tomado algún medicamento o droga? ☐ No ☐ Sí
Si respondió afirmativamente, indique el nombre del medicamento:________________________
7. ¿Es Ud. alérgico/a á algún medicamento? ☐ No ☐ Sí
Si respondió afirmativamente, indique el nombre del medicamento:________________________
8. ¿Tiene historia de asma, reacción alérgica, enfermedad respiratoria, ó reacción a contrastes ó tinturas usados en MRI, CT, ó Rayos-X? ☐ No ☐ Sí
9. ¿Tiene anemia u otra enfermedad que afecte su sangre, algún episodio de enfermedad de riñón, ó de ataques epilépticos?
Si respondió afirmativamente, descríbalos: ________________________ ☐ No ☐ Sí

Para los pacientes femeninos:
10. Fecha de su último periodo menstrual: _____/_____/_____ En la menopausia? ☐ No ☐ Sí
11. ¿Está embarazada ó tiene retraso con su periodo menstrual? ☐ No ☐ Sí
12. ¿Está tomando contraceptivos orales ó recibiendo tratamiento hormonal? ☐ No ☐ Sí
13. ¿Está tomando algún tipo de medicamento para la fertilidad ó recibiendo tratamientos de fertilidad? ☐ No ☐ Sí
Si responde afirmativamente, descríbalos a continuación: ________________________
14. ¿Está amamantado a su bebé? ☐ No ☐ Sí

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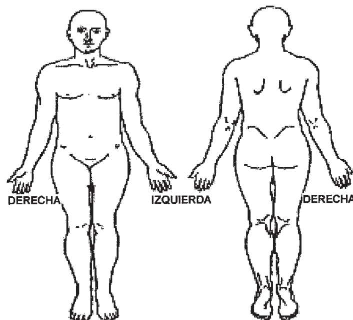
ADVERTENCIA: Ciertos implantes, dispositivos, u objetos pueden ser peligrosos y/o pueden interferir con el procedimiento de resonancia magnética (es decir, MRI, MR angiografía, MRI funcional, MR espectroscopía). **No entre** a la sala del escáner de MR o a la zona del laboratorio de MR si tiene alguna pregunta o duda relacionadas con un implante, dispositivo, u objeto. Consulte con el técnico o radiólogo de MRI ANTES de entrar a la sala del escáner de MR. **Recuerde que el imán del sistema MR está SIEMPRE encendido.**

Por favor indique si tiene alguno de los siguientes:

❒ Sí ❒ No Pinza(s) de aneurisma
❒ Sí ❒ No Marcapasos cardíaco
❒ Sí ❒ No Implante con desfibrilador para conversión cardíaca (ICD)
❒ Sí ❒ No Implante electrónico ó dispositivo electrónico
❒ Sí ❒ No Implante ó dispositivo activado magnéticamente
❒ Sí ❒ No Sistema de neuroestimulación
❒ Sí ❒ No Estimulador de la médula espinal
❒ Sí ❒ No Electrodos ó alambres internos
❒ Sí ❒ No Estimulador de crecimiento/fusión del hueso
❒ Sí ❒ No Implante coclear, otológico, u otro implante del oído
❒ Sí ❒ No Bomba de infusión de insulina ó similar
❒ Sí ❒ No Dispositivo implantado para infusión de medicamento
❒ Sí ❒ No Cualquier tipo de prótesis (ojo, peneal, etc.)
❒ Sí ❒ No Prótesis de válvula cardiaca
❒ Sí ❒ No Muelle ó alambre del párpado
❒ Sí ❒ No Extremidad artificial ó prostética
❒ Sí ❒ No Malla metálica (stent), filtro, ó anillo metálico
❒ Sí ❒ No Shunt (espinal ó intraventricular)
❒ Sí ❒ No Catéter y/u orificio de acceso vascular
❒ Sí ❒ No Semillas ó implantes de radiación
❒ Sí ❒ No Catéter de Swan-Ganz ó de termodilución
❒ Sí ❒ No Parche de medicamentos (Nicotina, Nitroglicerina)
❒ Sí ❒ No Cualquier fragmento metálico ó cuerpo extraño
❒ Sí ❒ No Implante tipo malla
❒ Sí ❒ No Aumentador de tejidos (e.g. pecho)
❒ Sí ❒ No Grapas quirúrgicas, clips, ó suturas metálicas
❒ Sí ❒ No Articulaciones artificiales (cadera, rodilla, etc.)
❒ Sí ❒ No Varilla de hueso/coyuntura, tornillo, clavo, alambre, chapas, etc.
❒ Sí ❒ No Dispositivo intrauterino (IUD), diafragma, ó pesario
❒ Sí ❒ No Dentaduras ó placas parciales
❒ Sí ❒ No Tatuaje ó maquillaje permanente
❒ Sí ❒ No Perforación (piercing) del cuerpo
❒ Sí ❒ No Audífono *(Quíteselo antes de entrar a la sala del escáner de MR)*
❒ Sí ❒ No Otro implante________________________
❒ Sí ❒ No Problema respiratorio ó desorden del movimiento
❒ Sí ❒ No Claustrofobia

Por favor marque en la imagen de abajo la localización de cualquier implante o metal en su cuerpo.



⚠ *¡AVISO IMPORTANTE!*

Antes de entrar a la zona de MR ó a la sala del escáner de MR, tendrá que quitarse todo objeto metálico incluyendo audífono, dentaduras, placas parciales, llaves, beeper, teléfono celular, lentes, horquillas de pelo, pasadores, todas las joyas (incluyendo "body piercing"), reloj, alfileres, sujetapapeles, clip de billetes, tarjetas de crédito ó de banco, toda tarjeta con banda magnética, monedas, plumas, cuchillos, corta uñas, herramientas, ropa con enganches de metal, y ropa con hilos metálicos.

Por favor consulte con el Técnico de MRI ó Radiólogo si tiene alguna pregunta o duda ANTES de entrar a la sala del escáner de MR.

NOTA: Es posible se le pida usar auriculares u otra protección de sus oídos durante el procedimiento de MR para prevenir problemas ó riesgos asociados al nivel de ruido en la sala del escáner de MR.

Atestiguo que la información anterior es correcta según mi mejor entender. Leo y entiendo el contenido de este cuestionario y he tenido la oportunidad de hacer preguntas en relación a la información en el cuestionario y en relación al estudio de MR al que me voy a someter a continuación.

Firma de la persona llenando este cuestionario: ______________________ Fecha____/____/____
Firma

Cuestionario lleno por: ❒Paciente ❒Pariente ❒Enfermera ______________________ ______________
Nombre en letra de texto — Relación con el paciente

Información revisada por: ______________________ ______________
Nombre en letra de texto — Firma

❒ Técnico de MRI ❒ Enfermera ❒ Radiólogo ❒ Otro ______________________

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