NewYork-Presbyterian
The University Hospital of Columbia and Cornell

50043

MAGNETIC RESONANCE (MRI) PROCEDURE SCREENING FORM

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Date: _____/_____/_____

Name: _____
LAST NAME FIRST NAME

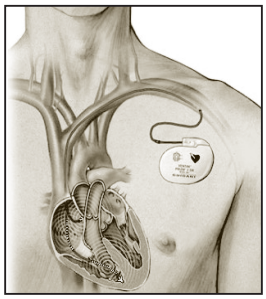
Date of Birth: _____/_____/_____ ☐ Male ☐ Female
MONTH DAY YEAR

Address: _____

City: _____ State: _____ Zip Code: _____

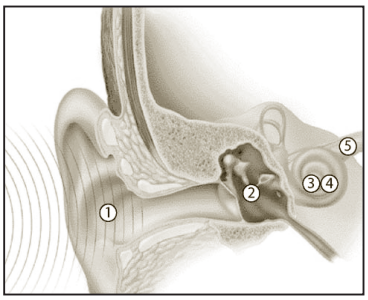
IF YOU HAVE EITHER OF THE DEVICES BELOW YOU CANNOT HAVE AN MRI.

Pacemaker/ Defibrillator (ICD)



STOP

Cochlear Implant



IMPORTANT

You must remove your clothes and shoes, all metallic objects including hearing aids, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools.

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

Please indicate if you have any of the following:

☐ Yes ☐ No Cardiac pacemaker or pacing wires
☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
☐ Yes ☐ No Cochlear, otologic, or other ear implant
☐ Yes ☐ No Tissue expander (e.g., breast)
☐ Yes ☐ No Implanted drug infusion device
☐ Yes ☐ No Aneurysm clip(s), When_____
☐ Yes ☐ No Neuro-stimulator (Deep Brain Stimulator)
☐ Yes ☐ No Other Stimulator: _____
☐ Yes ☐ No Prosthesis (eye, penile, limb, etc.)
☐ Yes ☐ No Artifical heart valve
☐ Yes ☐ No Eyelid spring or wire
☐ Yes ☐ No Stent, filter, or coil
☐ Yes ☐ No Programmable shunt
☐ Yes ☐ No Catheter or feeding tube with metal tip
☐ Yes ☐ No Radiation seeds
☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
☐ Yes ☐ No Any metallic fragment, foreign body or bullets
☐ Yes ☐ No Surgical staples, clips, metallic sutures or wire mesh
☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
☐ Yes ☐ No IUD, diaphragm, or pessary
☐ Yes ☐ No Dentures or braces
☐ Yes ☐ No Tattoo, permanent makeup or body piercing jewelry
☐ Yes ☐ No Hearing aid (Remove before entering the MR system room)
☐ Yes ☐ No Breathing problem and motion disorder
☐ Yes ☐ No Claustrophobia
☐ Yes ☐ No Hair Extensions

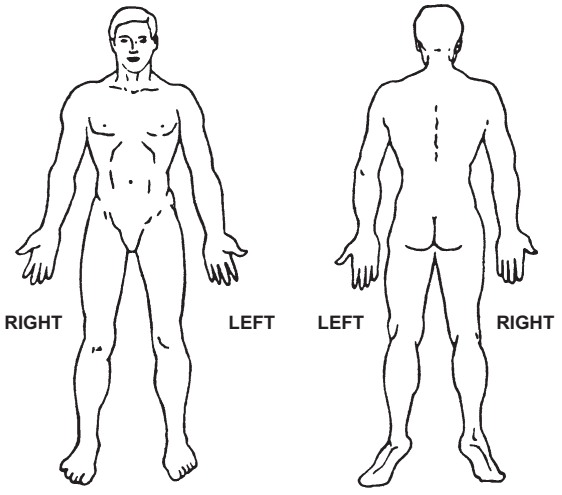
Reason for MRI _____

_____

Symptoms _____

_____

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



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Your MRI may require the administration of MRI contrast. This will be given by injection through a small needle placed into your vein. You may experience a sensation of the contrast being injected, which is normal and expected.

Have you ever had an injection of MRI contrast? (Gadolinium)
Have you ever had, as a result of MRI contrast any of the following:

Hives:	☐ No ☐ Yes
Shortness of breath:	☐ No ☐ Yes
Fainting or collapse:	☐ No ☐ Yes

Please ask the MRI staff if you have any question or concern BEFORE you enter the MR system room.

1. How much do you weigh? _____KG_____LBS.
2. Do you have any of the following conditions? ☐ Renal disease ☐ Seizure ☐ Respiratory disease
   If yes, please describe: _____
3. Are you on dialysis? ☐ No ☐ Yes
4. Have you had prior surgery or operation (e.g.heart surgery, arthoscopy) of any kind? ☐ No ☐ Yes
   If yes, please indicate the Date: _____/_____/_____
   Type of surgery _____
5. Have you had an injury to the eye involving a metallic object or fragment ☐ No ☐ Yes
   (e.g., metallic slivers, shavings, foreign body, etc.)?
   If yes, please describe: _____
6. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes
   If yes, please describe: _____
7. List any allergies: _____

For female patients:

8. Are you pregnant or suspect you might be pregnant? ☐ No ☐ Yes
9. Date of last menstrual period: _____/_____/_____ Post menopausal? ☐ No ☐ Yes
10. Breast Feeding? ☐ No ☐ Yes

I attest that the above information is correct to the best of my knowledge. I have 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: _____/_____/_____

Form Information reviewed by: _____

Form Completed by: ☐ Patient ☐ Relative ☐ Nurse: _____ Technologist: _____

Print Name Relationship to Patient _____

FILLED OUT BY MRI TECHNOLOGIST --- MRI TECHNOLOGIST VERIFICATION

1. Technologist read and signed the MRI screening sheet?	☐ Yes ☐ No
2. Patient was verbally screened?	☐ Yes ☐ No
3. Patient passed through the Ferromagnetic Portal?	☐ Yes ☐ No ☐ NA (Non-Ambulatory)
4. Patient was wanded?	☐ Yes ☐ No
5. I asked the patient if they had a pacemaker and or ICD (Implanted cardiac Defibrillator?	☐ Yes ☐ No

MRI Technologist Name: _____ Signature: _____

Date: _____/_____/_____ Time: _____ AM/PM

I attest to the above.