MRI PATIENT SCREENING FORM

Patient MRN: _____

Date: _____ Ordering Physician: _____

Name: _____ DOB: _____

Age: _____ Height: _____ Weight: _____ ☐Male ☐Female

Describe your symptoms/pain: _____

_____

1. Have you had prior surgery on the area being scanned: ☐Yes ☐ No If yes, please indicate below:

   Date: _____ Type of Surgery: _____

   Date: _____ Type of Surgery: _____

2. Have you had prior diagnostic imaging study or examination (MRI, CT) on the area being scanned today? ☐Yes ☐ No

   If yes, please list exam(s) and the facility preformed at: _____

3. Have you had an injury to the eye or any other part of the body involving a metallic object or fragment? ☐Yes ☐ No

   If yes, please describe: _____

4. Have you had any prior history of cancer? If yes, please indicate what type and when diagnosed?_____

5. Are you pregnant or experiencing a late menstrual? ☐Yes ☐ No

****

Please indicate if you have any of the following:

☐Yes ☐ No **Aneurysm Clip(s) or coils** Implant date _____	☐Yes ☐ No **Programmable Shunt**	☐Yes ☐ No **Wire Mesh Implant**
☐Yes ☐ No **Cardiac Pacemaker/Defibrillator**	☐Yes ☐ No **NON-Programmable Shunt**	☐Yes ☐ No **Eyelid Spring or Wire**
☐Yes ☐ No **Metallic Stent, Filter or Coil** Implant date_____	☐Yes ☐ No **Bone/Joint Pin, Screw, Nail, Plate, Etc.**	☐Yes ☐ No **IUD, Diaphragm, or pessary**
☐Yes ☐ No **Neuro-Stimulator System**	☐Yes ☐ No **Joint Replacement (hip, knee, etc.)**	☐Yes ☐ No **Metal Tissue Expander (breast)**
☐Yes ☐ No **Internal Electrodes or Wires**	☐Yes ☐ No **Surgical Staples, Clips, or Metallic Sutures**	☐Yes ☐ No **Medication Patch (e.g. Nicotine)**
☐Yes ☐ No **Heart Valve Prosthesis**	☐Yes ☐ No **Clip(s) implanted during a colonoscopy**	☐Yes ☐ No **Tattoo or permanent Makeup**
☐Yes ☐ No **Electronic/Magnetic Implant or Device**	☐Yes ☐ No **Baclofen/Insulin/Pain Infusion Pump**	☐Yes ☐ No **Body Piercing jewelry**
☐Yes ☐ No **Electronic Bone/Spinal Cord Stimulator**	☐Yes ☐ No **Artificial Prosthesis (eye, penile, limb, etc.)**	☐Yes ☐ No **Other Implant:**
☐Yes ☐ No **Cochlear, Hearing Aid or other Ear Implant**	☐Yes ☐ No **Triggerfish Contact Lens**	☐Yes ☐ No **Claustrophobia**
☐Yes ☐ No **Continuous Glucose Monitoring Device**	☐Yes ☐ No **False teeth, braces, retainers, dentures**	☐Yes ☐ No **Silver coated dressings**
☐Yes ☐ No **Magnetic Dental implant**	☐Yes ☐ No **Endoscopy clips**	☐Yes ☐ No **Bullets, BB's, Metal shrapnel**

ALLERGIES

Have you had a previous allergic reaction to MRI Gadolinium contrast material? ☐Yes ☐ No

If so, please explain _____

List any allergies including food, medication, and environmental _____

_____

CAROLINA NeuroSurgery & Spine ASSOCIATES

CONTRAST AGENT PROFILE
(*FOR CONTRAST STUDIES ONLY*)

Patient MRN: _____

Do you have a history of Diabetes? ☐Yes ☐ No

History of Kidney Disease including:

Kidney Surgery or transplant	☐Yes ☐ No
Single Kidney	☐Yes ☐ No
Cancer involving the kidney	☐Yes ☐ No
Acute Kidney injury	☐Yes ☐ No

Are you on Dialysis? If yes, what type? **Peritoneal or Hemodialysis**

Are you on any treatment for high blood pressure? ☐Yes ☐ No

If your doctor has ordered your scan with Contrast

During the examination, you may experience a cold sensation, headache, nausea, or dizziness. Less frequently, you may experience an allergic type reaction with itching and possibly hives (raised skin resembling mosquito bites). Other symptoms such as localized swelling of the eyes and lips, sneezing, difficulty breathing, or hypotension (low blood pressure) can occur. ******If you experience any of the above symptoms within 24 hours, please notify your referring physician or go to the emergency room******

Before entering the MRI room, you must remove ALL metallic objects including hearing aids, dentures, partial plates, keys, cell phones, beepers, eyeglasses, hairpins, barrettes, jewelry, watches, safety pins, paperclips, credit cards, pocketknives, cigarette lighters as well as wigs, hairpieces, extensions, weaves and toupees. Please consult the MRI Technologist if you have any questions or concerns <u>BEFORE</u> you enter the MRI room.

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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 have had the opportunity to ask questions regarding the MRI procedure I am about to undergo.

****I hereby authorize Carolina Neurosurgery & Spine Associates to release insurance information to Charlotte Radiology for billing purposes associated with the interpretation/reading of my MRI examination. I understand that I will receive two separate charges for this procedure; one for the MRI examination and one for the interpretation/reading.****

_____ _____ _____
Signature Date Relation to Patient

_____ _____
Technologist Date

****

(Office use only)

Exam_____

Brand of Contrast: **Gadavist** Lot# _____ Exp. Date _____

Amount of contrast _____ (mL's)

If applicable: Creatinine _____ Estimated GFR _____

Technologist Signature: _____ Date: _____

Tech Notes: _____

_____