The Children's Hospital of San Antonio
CHRISTUS Health

CHRISTUS SANTA ROSA Health System

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____/_____/_____

Name _____ Age _____ Height _____Weight _____
Last name First name Middle Initial

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

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.) relevant to today's exam? ☐ No ☐ Yes

If yes, please list: Body part Date Facility

MRI	_____	_____/_____/_____	_____
CT/CAT Scan	_____	_____/_____/_____	_____
X-Ray	_____	_____/_____/_____	_____
Ultrasound	_____	_____/_____/_____	_____

3. Have you experienced any problem related to a previous MRI examination or history of anxiety or claustrophobia? ☐ 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 hay fever, 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? renal failure, renal transplant, high blood pressure (hypertension), cancer, chemotherapy, radiation therapy, liver (hepatic) disease, a history of diabetes, 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 currently breastfeeding? ☐ No ☐ Yes

Permanent Part of Medical Record

MRI SCREENING FORM

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

Before entering the MR environment or MR system room, you must remove all metallic objects including masks, 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. The final review must be completed by Level 2 MRI Technologist or physician.

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 ____/____/____

Form Completed By: □ Patient □ Relative □ Nurse _____ _____
Print name Relationship to patient

Form Information Reviewed By: _____ _____
Print name Signature

□ MRI Technologist □ Radiologist □ Other _____

Permanent Part of Medical Record

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