Rev 09-2009

Vancouver Coastal Health Authority

☐ LGH ☐ RH ☐ UBCH ☐ VGH

# MAGNETIC RESONANCE IMAGING (MRI) PATIENT SCREENING FORM

NAME: _____

DATE: _____

or PATIENT LABEL

PLEASE FAX BOTH SIDES

Every patient scheduled for MRI **MUST** complete the following questionnaire prior to the being scanned. The technologist will be happy to answer any of your questions. **Please answer each question accurately and explain any marked "yes"**

Birth date: _____ Age: _____ Height____ft____in or ____cm Weight:_____kg or _____lbs

| **Do you have:** | **Yes** | **No** | **Unsure** | **If yes, explain** |
|---|---|---|---|---|
| Cardiac (Heart) Pacemaker or Wires (At any time in your life) | | | | |
| Artificial Heart Valves | | | | |
| Brain aneurysm clips | | | | |
| Metal in your eyes (At any time in your life) | | | | |
| Implanted Electrodes, Pumps or Catheters | | | | |
| Neurostimulators | | | | |
| Shrapnel, Bullets or other metal fragments | | | | |
| Any Tattoos – including permanent make up | | | | |
| Ear implants (Cochlear, Stapes) /Hearing Aid | | | | |
| Orthopedic (Bone) Screws, Pins, Plates, Rods (If yes, state location) | | | | |
| Breast tissue expander or other implants | | | | |
| Prosthesis (Eye, Penile, Leg, Arm, Joint, etc.) | | | | |
| Any Stents, Coils, or Filter in blood vessels | | | | |
| Dentures, retainer, braces, magnetic implants | | | | |
| Transdermal medication patches (Examples: Nitroglycerin for heart or Nicotine to stop smoking) | | | | |
| Body Piercing other than earrings | | | | |
| **Have you ever had surgery or operation on:** | | | | |
| Brain, Eye, or Ear | | | | |
| Heart | | | | |
| Neck, Chest, or Back (Spine) | | | | |
| Abdomen, Pelvis, Hips | | | | |
| Arms and/or Legs | | | | |
| Injection into a joint within the last 2 weeks | | | | |
| **Are you:** | | | | |
| Pregnant | | | | |
| Claustrophobic | | | | |

Please remove all your jewelry, watch, credit cards, coins and other metallic items (earrings, hair clips, bobby pins, etc.). A MRI staff member will instruct you about securing your items prior to entry into the examination area. I have read and understand the entire contents of this form. I affirm that the above information is true to the best of my knowledge and I hereby consent to the MRI study

_____ _____

Signature of person completing this form Date

_____ _____ _____

Relationship to patient if form not completed by patient Review Date Patient Initials

_____ _____

Signature of translator Date

MR Technologist Initials/Date ☐

If your MRI exam date occurs after the date the screening form was completed, you must review the screening form and alert the MR technologist of any changes. Please enter the date of review and your initials indicating confirmation of review.

# MRI Contrast Agent Questionnaire

Please answer the following questions:

| | Yes | No | Unsure |
|---|---|---|---|
| **Do you have:** | | | |
| Any allergies? | | | |
| Renal problems or family history of such (Kidney problem, disease, condition)? | | | |
| Type I or II Diabetes? | | | |
| Liver transplant or currently on a waiting list for a liver transplant? | | | |
| History of stroke? | | | |
| Peripheral vascular disease (Problems with blood vessel circulation in arms or legs) | | | |
| Ischemic Cardiac disease (Heart problems such as blocked arteries, history of Heart attack)? | | | |
| Asthma? If yes, is your asthma currently active? | | | |
| Sickle Cell or Hemolytic Anemia? | | | |
| **Have you had:** | | | |
| Previous injection of MRI contrast? | | | |
| Did you have a reaction? If yes, describe what happened: | | | |
| **Are you:** | | | |
| On Dialysis? | | | |
| Pregnant and/or Nursing? | | | |

PLEASE FAX BOTH SIDES

Your doctors believe it is in your best interest to have an MRI (Magnetic Resonance Imaging) examination that includes the intravenous or IV injection (through an arm or hand vein) of a contrast agent containing gadolinium.

Gadolinium-containing contrast agents are given during MRI examinations to provide additional information regarding the presence and extent of inflammation, infection, or tumors, and to evaluate blood vessels. Gadolinium is considered to be quite safe, with a very low risk of minor allergic reactions, and an extremely low risk of serious allergic reactions. Should you have a reaction, there will be a Physician available and medication on hand to treat the reaction.

I have read and understand the above information, and have had an opportunity to have my questions answered.

I agree to receive an intravenous injection of a contrast agent containing gadolinium as part of the MRI examination to provide further diagnostic information.

Signature of person completing this form _____ Date _____

Relationship to patient if form not completed by patient _____ Review Date _____ Patient Initials _____

Signature of translator _____ Date _____

MR Technologist Initials/Date _____

If your MRI exam date occurs after the date the screening form was completed, you must review the screening form and alert the MR technologist of any changes. Please enter the date of review and your initials indicating confirmation of review.