OREGON ADVANCED IMAGING

PRE-MRI SAFETY SCREENING

Exam Date: _____ **EXAM:** _____ **PID#:**

PATIENT INFORMATION

HEIGHT:_____ **WEIGHT:** _____

NAME: _____ **DOB:** _____ **AGE:** _____ **SEX:** _____

Referring Physician: **Primary Physician:**

ABSOLUTE CONTRAINDICATIONS:

Cardiac Pacemaker	☐ Yes	☐ No
Implanted cardiac defibrillator	☐ Yes	☐ No
Cochlear, otologic, or ear implant	☐ Yes	☐ No
Swan-Ganz catheter	☐ Yes	☐ No
Deep Brain Stimulator	☐ Yes	☐ No
Breast Tissue Expander	☐ Yes	☐ No

CONDITIONS THAT REQUIRE FURTHER INFO:

Neurostimulator / Aneurysm Clip(s)	☐ Yes	☐ No
Cartoid artery vascular clamp	☐ Yes	☐ No
Bone growth/fusion stimulator	☐ Yes	☐ No
Artificial limb or joint	☐ Yes	☐ No
Any prosthesis/implants (eye, penile, breast)	☐ Yes	☐ No
Intravascular stents, filters, or coils	☐ Yes	☐ No
Shunt (Spinal or intraventricular)	☐ Yes	☐ No
Insulin or infusion pump/ device	☐ Yes	☐ No
Heart Valve prosthesis/Internal pacing wires	☐ Yes	☐ No
Aortic Clip/Wire Sutures/Surgical Staples	☐ Yes	☐ No
Any metal fragments/ Body piercing(s)	☐ Yes	☐ No
Harrington/metal rods, screw in bones	☐ Yes	☐ No
Breast Biopsy Marker	☐ Yes	☐ No

ASSESSMNET/ MODIFICATION CONSIDERATIONS:

Electrodes (on body, head, or brain)	☐ Yes	☐ No
Tattooed makeup (eyeliner, lips, etc.)	☐ Yes	☐ No
Medication/Transdermal patch (Nitro, etc.)	☐ Yes	☐ No
IUD/Diaphragm/Pessary	☐ Yes	☐ No
Dentures/Hearing aid (remove before MRI)	☐ Yes	☐ No
Anxiety or panic attacks	☐ Yes	☐ No

HEALTH HISTORY:

MRSA (infectious disease)	☐ Yes	☐ No
Port-a-cath	☐ Yes	☐ No
Allergies – Drug / Latex / Iodine	☐ Yes	☐ No
Possible pregnancy or breast feeding?	☐ Yes	☐ No
History of tumor or cancer?	☐ Yes	☐ No

If YES, where? _____ When? _____

Medication for Diabetes?	☐ Yes	☐ No
Medication for High Blood Pressure?	☐ Yes	☐ No
History of kidney dialysis?	☐ Yes	☐ No
Previous kidney surgery?	☐ Yes	☐ No
Kidney transplant?	☐ Yes	☐ No
Solitary Kidney?	☐ Yes	☐ No
History of known cancer involving kidney?	☐ Yes	☐ No
Injury related to today's body part?	☐ Yes	☐ No

FOR OFFICE USE ONLY

Previous surgeries (invasive procedures):

_____

_____

_____

_____

_____

_____

_____

_____

Form Completed by: Patient _____ Relative/Other _____

Reviewed with MRI Staff: _____

Pandora Music Choice: _____

CONSENT: to be signed at time of appointment and in the presence of MRI Staff.

The procedure(s), alternatives, and risks have been explained to my satisfaction including the possible administration of contrast media. I hereby consent to the procedure(s).

Signature or Patient/Relative/Other: _____

MRI TECHNOLOGIST: _____ DATE: _____

FOR OFFICE USE ONLY

NAME: _____ **PID#:** _____

AREA BEING IMAGED: _____

BRAIN/NEURO SYMPTONS (headache, seizures, memory loss, etc.) _____

_____

_____

EXACT LOCATION OF PAIN – SPECIFIC (R/L, low, lateral, medial, RUQ, etc.) _____

_____

RADIATION OF PAIN (R/L, leg(s), feet, arm(s), other areas of spine.) _____

_____

LOCATION OF NUMBNESS/TINGLING: _____

DURATION OF PAIN/SYMPTOMS – SPECIFIC: _____

PAIN AGGRIVATED BY: _____

PREVIOUS SURGERY TO BODY PART? **IF YES,** SURGERY TYPE AND DATE: _____

PREVIOUS DIAGNOSIS OF CANCER? IF YES, DETAILS (type of cancer, diagnosis date, all treatments)
DISREGARD BASAL/SQUAMOUS SKIN CANCER:

_____

INJURY? **IF YES,** SPECIFIC DETAILS (fall off bike, rollover MVC, restrained/unrestrained.) _____

_____

DATE OF INJURY: _____

ADDITIONAL INFO NEEDED FOR SPECIFIC STUDIES

ABDOMEN:

Diverticulitis/ Crohns Disease/ Diverticulosis: specify if in large or small intestine (or both)
Cholethiasis: of gallbladder, bile duct (or both) Obstruction?
Hydronephrosis: congenital or acquired? Obstruction? Infection?

BRAIN:

If CVA: specify location if known (cerebral arteries, carotid, vertebral, basiliar, cerebellar.
If hemorrhage: location of hemorrhage (brainstem, cerebellum) Acute, subacute, chronic.
Type of hemorrhage epidural, subdural, subarachnoid)

SPINE:

Specify with or without myelopathy
Previous MD diagnosis of osteoporosis or osteopenia