O P E N
ADVANTAGE
M R I
We scan with compassion

MRI Patient Screening Sheet

Patient Name: ____ Date of Birth: ____________________

Referring Physician: __________________________________ ______ Date of Exam: ____________________

If you have a pacemaker, aneurysm clip or have had brain surgery, let us know immediately.

Patient weight: ______________ Current medications: ____

Allergies to medications / drugs: YES or NO If yes, which: ____________________________________

Have you ever had cancer? YES or NO If yes, what type: ____________________________________

Have you ever had radiation treatment or chemotherapy: YES or NO

What symptoms / problems are you having: ____

Have you had surgery related to this problem: YES or NO When? ______________________________

Have you had trauma related to this area / problem: YES or NO When? ______________________________

PLEASE INDICATE IF YOU HAVE THE FOLLOWING:

Cardiac pacemaker	Y	N	Diaphragm / IUD	Y	N
Aneurysm clip	Y	N	Renal Shunt	Y	N
Implanted drug infusion device	Y	N	Intraventricular shunt	Y	N
Bone growth stimulator	Y	N	Artificial limb	Y	N
Neurostimulator (TENS unit)	Y	N	Any orthopedic item: pins, rods, screws,		
Any type of biostimulator	Y	N	nails, clips, plates, wires	Y	N
Electrodes / pacing wires	Y	N	Any type of removable dental item	Y	N
Cochlear implant / mid-ear implant	Y	N	Hearing aid	Y	N
Gianturco coil (spring embolus coil)	Y	N	Homolytic or sickle cell anemia	Y	N
Intravascular filter / coil stent	Y	N	Renal disease / diabetes / dialysis	Y	N
Any type of surgical clip or staple	Y	N	Claustrophobia	Y	N
Heart valve prosthesis	Y	N	Are you pregnant?	Y	N
Penile prosthesis	Y	N	Previous metal in eye	Y	N
Orbital eye prosthesis	Y	N	Asthma	Y	N
Shrapnel or bullet	Y	N	Are you breastfeeding?	Y	N
Tattooed eyeliner	Y	N			

ANSWER ONLY IF YOUR CHILD IS BEING SCANNED

Was your child born at term Y N If not, how many weeks premature? ____________________

Any problems during or after birth Y N If so, please describe: ____________________________

Any developmental problems? Y N If so, please describe: ____________________________

I attest that the above information is correct to the best of my knowledge. I have read and understand the content of this form.

Patient Signature: ____ Date: ____________________

OFFICE USE ONLY:

Gadolinium____________cc's IV / Time: ______________ Site: ____________________________________

My signature confirms that I have verbally ordered the above medication and / or IV.

Physician Signature: ____ Date: ________________ Time: ___________