



## PRE-MRI SCREENING FORM

 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
dd mm yyyy

X-Ray No: \_\_\_\_\_

 Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Last name First name

Birth Date: \_\_\_\_\_ NRIC/PP No: \_\_\_\_\_

 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.)?  No  Yes

If yes, please list:                      Body part                      Date                      Facility

MRI                      \_\_\_\_\_                      \_\_\_\_/\_\_\_\_/\_\_\_\_                      \_\_\_\_\_

CT/CAT Scan                      \_\_\_\_\_                      \_\_\_\_/\_\_\_\_/\_\_\_\_                      \_\_\_\_\_

X-Ray                      \_\_\_\_\_                      \_\_\_\_/\_\_\_\_/\_\_\_\_                      \_\_\_\_\_

Ultrasound                      \_\_\_\_\_                      \_\_\_\_/\_\_\_\_/\_\_\_\_                      \_\_\_\_\_

Nuclear Medicine                      \_\_\_\_\_                      \_\_\_\_/\_\_\_\_/\_\_\_\_                      \_\_\_\_\_

Other                      \_\_\_\_\_                      \_\_\_\_/\_\_\_\_/\_\_\_\_                      \_\_\_\_\_

 3. Have you experienced any problem related to a previous MRI examination or MR procedure?  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 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 (Kidney) failure, renal (Kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease 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 or hormonal treatments?  No  Yes

 13. Are you taking any type of fertility medication or having fertility treatments?  No  Yes

If yes, please describe: \_\_\_\_\_

 14. Are you currently breastfeeding?  No  Yes

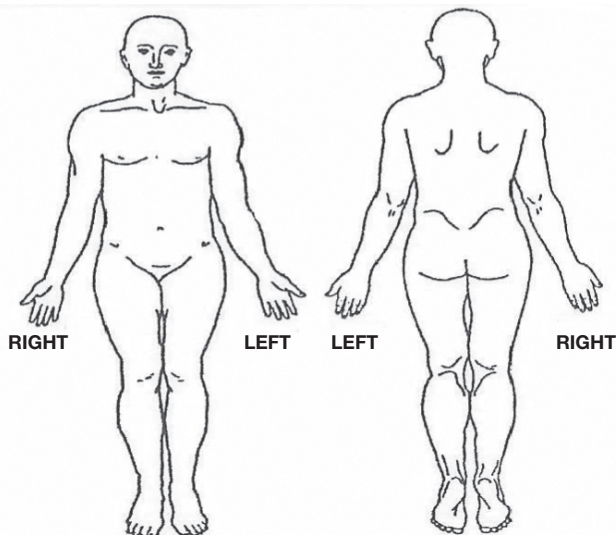


**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. 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 Cardiac pacemaker
- Yes  No Implanted cardioverter defibrillator (ICD)
- Yes  No Electronic implant or device
- Yes  No Magnetically-activated implant or device
- Yes  No Neurostimulation system
- Yes  No Spinal cord stimulator
- Yes  No Internal electrodes or wires
- Yes  No Bone growth/bone fusion stimulator
- Yes  No Cochlear, otologic, or other ear implant
- Yes  No Insulin or other infusion pump
- Yes  No Implanted drug infusion device
- Yes  No Any type of prosthesis (eye, penile, etc.)
- Yes  No Heart valve prosthesis
- Yes  No Eyelid spring or wire
- Yes  No Artificial or prosthetic limb
- Yes  No Metallic stent, filter, or coil
- Yes  No Shunt (spinal or intraventricular)
- Yes  No Vascular access port and/or catheter
- Yes  No Radiation seeds or implants
- Yes  No Swan-Ganz or thermodilution catheter
- Yes  No Medication patch (Nicotine, Nitroglycerine)
- Yes  No Any metallic fragment or foreign body
- Yes  No Wire mesh implant
- Yes  No Tissue expander (e.g., breast)
- Yes  No Surgical staples, clips, or metallic sutures
- Yes  No Joint replacement (hip, knee, etc.)
- Yes  No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes  No IUD, diaphragm, or pessary
- Yes  No Dentures or partial plates  
*(Remove before entering MR room)*
- Yes  No Tattoo or permanent makeup (eyeliner, lips, etc.)
- Yes  No Body piercing jewelry
- Yes  No Hearing aid  
*(Remove before entering MR room)*
- Yes  No Endoscopic capsule
- Yes  No Other implant \_\_\_\_\_
- Yes  No Breathing problem or motion disorder
- Yes  No Claustrophobia

**Please mark on the figure(s) below the location of any implant or metal inside of or on your body.**



**IMPORTANT INSTRUCTIONS**

**Before entering the MR environment or MR system room, you must remove all metallic objects including 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 radiographer if you have any question or concern **BEFORE** you enter the MR system room.**

**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 confirm that the above information is correct to the best of my knowledge.

Signature of person completing form: \_\_\_\_\_  
Signature

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Form Completed By:  Patient  Relative  Nurse \_\_\_\_\_  
Print name Relationship to patient

To be completed by MRI facility.

Form Information Reviewed By: \_\_\_\_\_  
Print name Signature

Radiographer  Nurse  Other \_\_\_\_\_

Comments: \_\_\_\_\_