ASSOCIATES

RADIOLOGIC CLINIC

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PRE-MRI SCREENING FORM

Date: ____/____/____ (dd / mm / yyyy) X-Ray No: _____

Name: _____ (Last name / First name) Height: _____ Weight: _____

Birth Date: _____ NRIC/PP No: _____

1. Have you ever had surgery or any similar invasive procedure? ❑ No ❑ Yes
   If yes, please list: _____ Date (dd / mm / yyyy)
   Type: _____ ____/____/____
   Type: _____ ____/____/____

2. Have you had any previous studies? ❑ No ❑ Yes
   If yes, please list: _____

	Body part	Date (dd / mm / yyyy)	Where
MRI		____/____/____	
CT/CAT Scan		____/____/____	
X-Ray		____/____/____	
Ultrasound		____/____/____	
Nuclear Medicine		____/____/____	

3. Have you ever worked with metal (grinding, fabricating, etc.) or ever had an injury to the eye involving a metallic object (e.g. metallic silvers, shavings, foreign body)? ❑ No ❑ Yes
   If yes, please describe: _____

4. Are you currently taking or have you recently taken any medication? ❑ No ❑ Yes
   If yes, please list: _____

5. Do you have anemia or any diseases that affect your blood, a history of renal disease or seizures? ❑ No ❑ Yes
   If yes, please describe: _____

6. Do you have drug allergies? ❑ No ❑ Yes
   If yes, please list: _____

7. Have you ever had asthma, allergic reaction, respiratory disease, or other reaction to a contrast medium or dye used for an MRI or CT examination? ❑ No ❑ Yes
   If yes, please describe: _____

FOR FEMALE PATIENTS ONLY

8. Are you pregnant or experiencing a late menstrual period? ❑ No ❑ Yes
9. Are you breast feeding? ❑ No ❑ Yes
10. Date of last menstrual period: ____/____/____ (dd / mm / yyyy)
11. Are you taking any type of fertility medication or having fertility treatments? ❑ No ❑ Yes
12. Are you taking oral contraceptives or receiving hormone treatment? ❑ No ❑ Yes

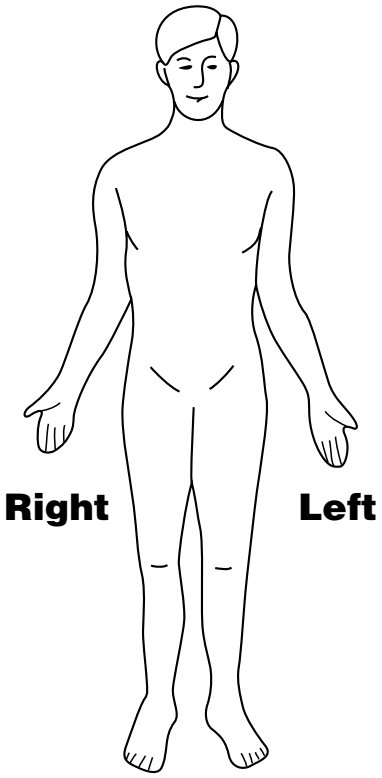
... Cont'd on reverse

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following. Do you have any of the following:

❑ Yes	❑ No	Cardiac pacemaker
❑ Yes	❑ No	Implanted cardiac defibrillator
❑ Yes	❑ No	Aneurysm clip(s)
❑ Yes	❑ No	Carotid artery vascular clamp
❑ Yes	❑ No	Neurostimulator
❑ Yes	❑ No	Insulin or infusion pump
❑ Yes	❑ No	Implanted drug infusion device
❑ Yes	❑ No	Bone growth/fusion stimulator
❑ Yes	❑ No	Cochlear, otologic, or ear implant
❑ Yes	❑ No	Any type of prosthesis (eye, penile, etc.)
❑ Yes	❑ No	Heart valve prosthesis
❑ Yes	❑ No	Artificial limb or joint
❑ Yes	❑ No	Electrodes (on body, head, or brain)
❑ Yes	❑ No	Intravascular stents, filters, or coils
❑ Yes	❑ No	Shunt (spinal or intraventricular)
❑ Yes	❑ No	Vascular access port and/or catheter
❑ Yes	❑ No	Swan-Ganz catheter
❑ Yes	❑ No	Any implant held in place by a magnet
❑ Yes	❑ No	Transdermal delivery system (Nitro)
❑ Yes	❑ No	IUD or diaphragm
❑ Yes	❑ No	Tattooed makeup (eyeliner, lips, etc.)
❑ Yes	❑ No	Body piercing(s)
❑ Yes	❑ No	Any metal fragments
❑ Yes	❑ No	Internal pacing wires
❑ Yes	❑ No	Aortic clip
❑ Yes	❑ No	Metal or wire mesh implants
❑ Yes	❑ No	Wire sutures or surgical staples
❑ Yes	❑ No	Harrington rods (spine)
❑ Yes	❑ No	Metal rods in bones
❑ Yes	❑ No	Joint replacement
❑ Yes	❑ No	Bone/joint pin, screw, nail, wire, plate
❑ Yes	❑ No	Hearing aid *(Remove before MRI)*
❑ Yes	❑ No	Dentures *(Remove before MRI)*
❑ Yes	❑ No	Breathing disorder
❑ Yes	❑ No	Motion disorder
❑ Yes	❑ No	Claustrophobia
❑ Yes	❑ No	Anxiety

Other, please explain: _____

Please mark on the figure below, the location of any implant or metal inside of or on your body.



Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewellery, watch, safety pins, paperclips, money clip, credit cards, handphones, pagers, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material.

NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS DURING THE MRI EXAMINATION.

_____ Date: ____/____/____
Signature of Person Completing Form dd mm yyyy

Form completed by: ❑ Patient ❑ Relative: _____
Name & relationship to patient

❑ Physician or other: _____
Name & relationship to patient

To be completed by the MRI Facility

Radiographer/Nurse: _____

Comments: _____

_____

_____