THE IMAGING CENTER - COOKEVILLE REGIONAL MEDICAL CENTER - MRI QUESTIONNAIRE PART 1

WARNING: Certain implants, devises or objects may be hazardous to you in the MRI environment or MR system room.
Do not enter the MR environment system room if you have any question or concern regarding an implant, devise, or object. Please indicate if you have any of the following.

❑Yes ❑No **Cardiac Pacemaker**	❑Yes ❑No Heart valve prosthesis	❑Yes ❑No Metal or wire mesh implants
❑Yes ❑No **Implanted cardiac defibrillator**	❑Yes ❑No Artificial limb or joint	❑Yes ❑No Wire sutures or surgical staples
❑Yes ❑No **Aneurysm clip(s)/Coils**	❑Yes ❑No Electrodes (on body, head, or brain)	❑Yes ❑No Harrington rods (spine)
❑Yes ❑No **Carotid artery vascular clamp**	❑Yes ❑No Vascular access port and/or catheter	❑Yes ❑No Metal rods in bones
❑Yes ❑No **Internal pacing wires** ***Initial*** ___	❑Yes ❑No Swan-Ganz catheter	❑Yes ❑No Joint replacement _____
❑Yes ❑No **Intravascular stents, filters, or coils**	❑Yes ❑No Any implant held in place by a magnet	❑Yes ❑No Bone/joint pin, screw, nail, wire, plate
❑Yes ❑No **Shunt (spinal or intraventricular)**	❑Yes ❑No Transdermal delivery system (Nitro)	❑Yes ❑No Hearing aid ***(Remove before MRI)***
❑Yes ❑No **Penile Implant**	❑Yes ❑No IUD or Diaphragm	❑Yes ❑No Dentures ***(Remove before MRI)***
❑Yes ❑No **Any prosthesis or implant**	❑Yes ❑No Tattooed makeup (eyeliner, lips, etc.)	❑Yes ❑No Metal Shavings in Eyes
❑Yes ❑No Implanted drug infusion device	❑Yes ❑No Body piercing(s)	❑Yes ❑No Allergies to medications
❑Yes ❑No Bone growth/fusion stimulator	❑Yes ❑No Any metal fragments	❑Yes ❑No Insulin or infusion pump
❑Yes ❑No Cochlea, otologic, or ear implant	❑Yes ❑No Aortic clip	❑Yes ❑No Other implant _____

Weight: _____ Height: _____ **ARE YOU: Pregnant? ❑Yes ❑No** **Taking birth control? ❑Yes ❑No** Last menstrual cycle? _____

Reviewed by PCA: _____ **Office Staff:** _____

Before your MRI you will be asked to change into CRMC clothing. All jewelry, body piercings, hair pins and metallic objects will need to be removed.

Clothes containing metal fibers can be dangerous during MRI (Magnetic Resonance Imaging). Putting metal into the scanner can actually react or heat up and burn the patient.

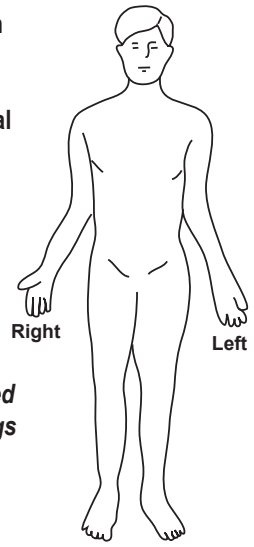
Some clothing companies do not identify the metallic components of multipurpose fabrics incorporated in products ranging from athletic apparel like sports bras, yoga pants including socks and underwear. This makes it very hard for the MRI personnel to know if your clothing has any metal components.

If you fail to remove all your clothing and choose to wear additional items other than CRMC's gowns, robes and or pants, you could be placing yourself at an increased risk of serious burns.

By signing this form you are acknowledging that you were informed of the possible dangers.

Patient Initial: _____

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



You are required to wear earplugs or earphones during the MRI examination.

SUBSEQUENT MRI: Patient has been screened/ confirmed by Medical Records that no procedures have been performed and no medical devices have been implanted since the previous MRI on_____

IT IS SAFE TO PROCEED WITH THE MRI EXAM:

Exam: _____

Date: _____

Time: _____

Caregiver/Nurse (print name): _____

Signature: _____

MRI Technologist: _____

Contrast: _____ Amount: _____

SUBSEQUENT MRI: Patient has been screened/ confirmed by Medical Records that no procedures have been performed and no medical devices have been implanted since the previous MRI on_____

IT IS SAFE TO PROCEED WITH THE MRI EXAM:

Exam: _____

Date: _____

Time: _____

Caregiver/Nurse (print name): _____

Signature: _____

MRI Technologist: _____

Contrast: _____ Amount: _____

_____
GUARDIAN/PATIENT NAME (PRINT)

_____
GUARDIAN/PATIENT SIGNATURE

CRMC STAFF ONLY **MR #**_____

REVIEWED BY:

RN: _____ **MRI Tech:** _____

Date: _____ **Time:** _____ **Date:** _____ **Time:** _____

Procedure: _____

Contrast: _____ Amount: _____

Procedural: _____ Time Out: _____

Interpreter: _____ MRI Tech _____

865-A

Cookeville Regional Medical Center

The Imaging Center Coding Information

PAIN

Location _____

Type: _____

Side: ❑ Left ❑ Right ❑ Bilateral

How much does it hurt? Scale: 1-10 _____

CANCER HISTORY

❑ Have you ever had Cancer? ❑Yes ❑No

What type of cancer?_____

Approx date of last evaluation for Cancer:_____

GENERAL

❑ Bleeding Location: _____

❑ Swelling Location: _____

Injury: ❑ Auto accident ❑ Fall ❑ Assault

❑ High Blood Pressure

❑ Diabetes

❑ Other, please specify:_____

_____

PRE-OP TESTING

Type of surgery planned:

_____

NEUROLOGICAL

❑ Headaches ❑ Confusion ❑ Syncope

❑ Dizziness and/or Loss of Balance

❑ Visual Problems/Blurry Vision

❑ Weakness / Numbness / Tingling

Location: _____

Are you? ❑ R Handed ❑ L Handed

RESPIRATORY

❑ Cough ❑ Shortness of Breath

❑ Chest Tightness ❑ COPD ❑ Asthma

Do you smoke cigarettes? ❑ Yes ❑ No

If yes, Packs/Day_____Years smoking _____

Chest Pain Location: _____

❑ Sternal/Precordial ❑ R ❑ L ❑ Diffuse

Type: ❑ Stabbing ❑ Crushing ❑ Dull

ABDOMINAL

❑ Nausea ❑ Vomiting ❑ Diarrhea

❑ Other stomach issues:

Pain Location: _____

❑ RUQ ❑ RLQ ❑ LUQ

❑ LLQ ❑ Epigastric ❑ Diffuse

Pain Type: _____

❑ Stabbing ❑ Dull ❑ Constant

❑ Intermittent ❑ Cramping

REQUIRED

When did symptoms start? _____

Visit type: ❑ Initial ❑ Subsequent

Date last visit for this problem?_____

Previous Relevant Surgeries:_____

_____

_____

IV Contrast Type/Amount: _____

Oral Contrast Type/Amount: _____

Radiopharm Type/Amount: _____

PATIENT ID STICKER

❑ Patient unable to communicate

Information from: _____