## 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 **Implanted cardiac defibrillator**
❑Yes ❑No **Aneurysm clip(s)**
❑Yes ❑No **Carotid artery vascular clamp**
❑Yes ❑No **Internal pacing wires Initial**
❑Yes ❑No **Intravascular stents, filters, or coils**
❑Yes ❑No **Shunt (spinal or intraventricular)**
❑Yes ❑No **Any prosthesis or implant**
❑Yes ❑No Insulin or infusion pump
❑Yes ❑No Implanted drug infusion device
❑Yes ❑No Bone growth/fusion stimulator
❑Yes ❑No Cochlea, otologic, or ear implant
❑Yes ❑No Heart valve prosthesis
❑Yes ❑No Artificial limb or joint
❑Yes ❑No Electrodes (on body, head, or brain)
❑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 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 Metal Shavings in Eyes
❑Yes ❑No Allergies to medications
❑Yes ❑No Other implant ____________

List: ______________________________

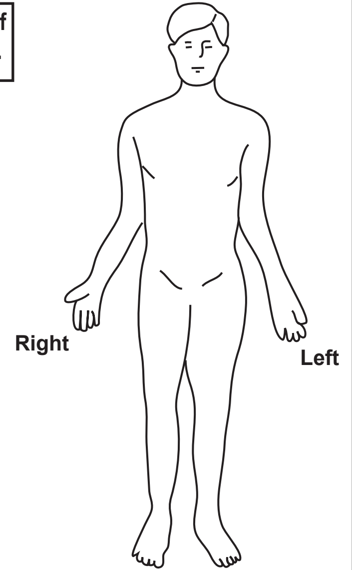
Weight: __________ Height: __________

**Is there a chance you maybe pregnant?** ❑Yes ❑No

Are you currently taking birth control? ❑Yes ❑No

When was your last menstrual cycle? __________

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




What problems are you having? ______________________________

______________________________

______________________________

Is this due to an injury? ______________________________

*Explanation:*______________________________

How long has this been going on? ____________________

Have you ever been diagnosed with cancer? ____________________

Did you receive: ❑ Chemotherapy ❑ Radiation

**Reviewed by PCA**__________**Office Staff**__________

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

I agree to take responsibility for programming my medical device

(a) ______________________________

putting it into MRI safe scan mode and to reset the device after my exam as directed by the manufacturer's instructions.I acknowledge and understand the risks and consent to proceed with the MRI exam.

**Signature** __________ **Date** __________ **Time** __________

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

PATIENT NAME (PRINT): ______________________________ DATE: __________

**SIGNATURE OF PATIENT/GUARDIAN** **REVIEWED BY MRI TECH** **TIME**

PATIENT ID STICKER

______________________________

Medical record number

**To be completed by the MRI Facility:**

Procedure:______________________________

Contrast: ____________________ Amount: __________

Procedural ____________________ Time Out: __________

Intepreter: ____________________ MRI Tech __________

*865-A*

Form 865-A (Rev. 1/18)