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4930 Overland Drive
Lawrence, KS 66049

medimageks.com

Patient Name:________________________**Date of Birth:**____________ **Height**__________**Weight**_______

MRI SAFETY SCREENING AND MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- ☐ YES ☐ NO INJURY TO THE EYES INVOLVING METAL?
- ☐ YES ☐ NO CARDIAC PACEMAKER/PACER WIRES/ICD
- ☐ YES ☐ NO HEART SURGERY OR HEART VALVE?
- ☐ YES ☐ NO BRAIN ANEURYSM CLIPS OR BRAIN SURGERY?
- ☐ YES ☐ NO SHUNTS/STENTS/FILTERS/INTRAVASCULAR CLIPS?
- ☐ YES ☐ NO ANY SURGICAL CLIPS NOT LISTED ABOVE?
- ☐ YES ☐ NO EYE SURGERY/IMPLANTS/SPRINGS/WIRES/ RETINAL TACKS?
- ☐ YES ☐ NO ENDOSCOPIC/GI PROCEDURE?
- ☐ YES ☐ NO EAR SURGERY/COCHLEAR IMPLANTS/HEARING AIDS/STAPES IMPLANTS?
- ☐ YES ☐ NO ORTHOPEDIC PINS/SCREWS/RODS/ JOINT PROSTHESIS?
- ☐ YES ☐ NO ARE YOU WEARING A SUPPORT BRACE?
- ☐ YES ☐ NO NEUROSTIMULATOR/BIOSTIMULATOR?
- ☐ YES ☐ NO ELECTRICAL/MECHANICAL/MAGNETIC IMPLANTS?
- ☐ YES ☐ NO METAL MESH IMPLANTS/WIRE SUTURES/ STAPLES CLIPS/INTERNAL ELECTRODES?
- ☐ YES ☐ NO IMPLANTED DRUG INFUSION PUMP/INSULIN PUMP?
- ☐ YES ☐ NO TATTOOS/PERMANENT MAKE-UP/BODY PIERCING/ MEDICATION PATCHES?
- ☐ YES ☐ NO DENTURES/PARTIALS/DENTAL IMPLANTS?
- ☐ YES ☐ NO GUNSHOT WOUNDS/SHRAPNEL/ BB'S?
- ☐ YES ☐ NO PINS IN CLOTHING/HAIR/HAIR PIECES/WIGS?

CONTRAST QUESTIONNAIRE:

- ☐ YES ☐ NO ARE YOU BEING TREATED FOR HIGH BLOOD PRESSURE?
- ☐ YES ☐ NO DO YOU HAVE RENAL(KIDNEY) DISEASE?
- ☐ YES ☐ NO ARE YOU DIABETIC?
- ☐ YES ☐ NO DO YOU HAVE LIVER DISEASE?
- ☐ YES ☐ NO HAVE YOU EVER HAD AN ORGAN TRANSPLANT?
- ☐ YES ☐ NO ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

IF SO PLEASE LIST:____

____

- ☐ YES ☐ NO ANY KNOWN DRUG ALLERGIES?
  IF SO PLEASE LIST______________________________
  ____
- ☐ YES ☐ NO HAVE YOU EVER HAD AN MRI BEFORE
  IF YES ANY PROBLEMS__________________________
  ____
- ☐ YES ☐ NO HAVE YOU EVER HAD MRI CONTRAST BEFORE?
  IF YES ANY PROBLEMS__________________________
  ____
- ☐ YES ☐ NO ARE YOU CLAUSTROPHOBIC?
- ☐ YES ☐ NO ANY CHANCE OF PREGNANCY?
- ☐ YES ☐ NO ARE YOU CURRENTLY BREAST FEEDING?
- ☐ YES ☐ NO HAVE YOU HAD SURGERY? IF YES SO:
  TYPE DATE
  ____
  ____
  ____
- ☐ YES ☐ NO PERSONAL HISTORY OF CANCER? IF SO:
  TYPE
  ____
- ☐ YES ☐ NO CHEMOTHERAPY/RADIATION? IF SO:
  DATE OF LAST TREATMENT
  ____

ACKNOWLEDGMENT

I have read and understand the contents of this form. I attest that the information provided on this form is correct to the best of my knowledge I acknowledge depending on the necessity and my renal function, contrast maybe administered. I acknowledge that I am aware of the possible side effects, and I have had the opportunity to ask questions related to this form, the MRI procedure and the contrast.

PATIENT SIGNATURE:________________________________

DATE:_____________

TECHNOLOGIST SIGNATURE________________________CONTRAST NAME__________________ DOSE___________ LOT#________________

DATE_______________ EXPIRATION DATE_________________ROUTE_________________________