HAMILTON MEDICAL CENTER

MRI PATIENT HISTORY AND SCREENING

Today's Date _____ / _____ / _____ Date of Exam _____ / _____ / _____

Patient Name _____ SS # _____

Sex ____ Birthday _____ / _____ / _____ Weight _____ Age _____

Address _____ Telephone # (work) _____

_____ Telephone # (home) _____

Doctor _____ Symptoms _____

Previous MRI Study? Yes or No (Please circle)
Date and Type of MRI exams below if yes.

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have any of the following:

A pacemaker? _____
An aneurysm clip(s)? _____
A Neurostimulator? _____
Cochlear Implant? _____
Any Implanted devices? _____
Metallic implant questions: www.mrisafety.com

Have you had surgery other than dental surgery or radiation therapy?

1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever worked in a machine shop or similar environment where you may have been subject to small metal slivers? Yes or No (Please circle one).

Allergies: _____ Currently pregnant: _____

_____ _____
Patient Signature Date

_____ _____
Signature of Person Giving Consent if not patient. Date
Relationship to patient: _____

_____ _____
Technologist Signature Date
(Scan to PACS, do not forward to Medical Records)

_____

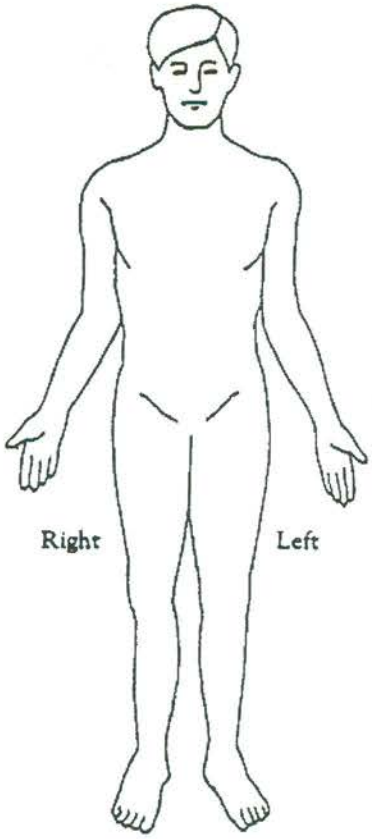
Patient Identification Label

HAMILTON MEDICAL CENTER

MRI History and Screening Form

Deleted: <sp>¶

Please mark on the drawing the location of any metal inside your body.



The following items can interfere with MR Imaging and some can actually be hazardous to your safety.

Please answer each question below:

Yes / No Cardiac pacemaker
Yes / No Brain clips
Yes / No Aortic clips
Yes / No Neurostimulator (TEENS-Unit)
Yes / No Heart valve
Yes / No Insulin pump
Yes / No Electrodes
Yes / No Hearing Aids
Yes / No IUD
Yes / No Shunts
Yes / No Harrington rods
Yes / No Shrapnel
Yes / No Dentures/Partials
Yes / No Metal slivers in the eyes
Yes / No Cochlear implants
Yes / No Tattoo eyeliner
Yes / No Medication patches
Yes / No ECG wires
Yes / No Catheters inserted
Yes / No Any devices attached or inserted into body
Others (Please list other Metal)

_____

_____

Do not enter the scan room with any of these items: Glasses, removable dental work, hearing aid, jewelry, watch, wallet/money clip, pens/pencils, keys, coins, pocket knife, metal zippers/buttons, belt buckle, shoes, magnetic strip cards (credit cards, bank cards), hairpins/barrettes, metal bra hooks, bra / girdle underwire support, sanitary belt, safety pins.

_____ _____
Patient Signature Date

_____ _____
Signature of Person Giving Consent if not patient. Date
Relationship to patient: _____

_____ _____
Technologist Signature Date
(Scan to PACS, do not forward to Medical Records)

_____