Patient Name; _____ Date: _____

DOB: _____ Body Part: _____

MRI Screening Form

Do you have an Implanted Cardiac Pacemaker or Cardioverter Defibrillator (ICD)?

- YES
- NO

If you answered YES and you have an Implanted Cardiac Defibrillator (ICD), please discontinue filling out this form. We do not schedule patients with these devices at EmergeOrtho. Our office will reach out to you within 48 hours to schedule your MRI at another location. If you have questions or concerns call our office at 910-769-9630.

If you answered NO, please continue with this form.

If you currently have any form of body jewelry on, are you able to take off all your jewelry completely before your MRI appointment? *

__ I do not wear body jewelry.
__ I am able to remove my body jewelry before my appointment.
__ I am unable to remove by body jewelry.

IMPORTANT INSTRUCTIONS

BEFORE ENTERING THE MR ENVIRONMENT, YOU MUST REMOVE ALL METALLIC OBJECTS INCLUDING HEARING AIDS, DENTURES, PARTIAL PLATES, KEYS, CELL PHONE, ELECTRONICS, EYEGLASSES, HAIR PINS, BARRETTES, JEWELRY, BODY PIERCING JEWELRY, WATCH, SAFETY PINS, PAPERCLIPS, MONEY CLIP, CREDIT CARDS, BANK CARDS, MAGNETIC STRIP CARDS, COINS, PENS, POCKET KNIFE, NAIL CLIPPER, TOOLS, CLOTHING WITH METAL FASTENERS, & CLOTHING WITH METALLIC THREADS (DRY FIT/COPPER FIT CLOTHING).

Weight: *

Height: *

Please list any surgeries performed in your lifetime:

Please answer the following questions and provide further information for any "Yes" answers.

Have you ever had an MRI examination? *

- YES
- NO

If YES, When and Where?

Have you ever had an injury to your eye(s) involving metal?*

- YES
- NO

Do you CURRENTLY wear any diabetic monitoring devices? (i.e. Insulin pump, dexicom monitor) *

- YES
- NO

If YES, what device?

Please note: All devices used to monitor your diabetes will need to be removed before entering the MRI scan room.

Do you have a port that requires access to administer contrast?*

- YES
- NO

Do you CURRENTLY have any retained bullets, shrapnel, BBs, or other metallic foreign bodies located anywhere in your body? *

- YES
- NO

Do you require Oxygen at the time of your scan? *

- YES
- NO

Do you need assistance transferring to the MRI table? *

- YES
- NO

Are you claustrophobic? *

- YES
- NO

Will you need an oral medication for your upcoming MRI? *

- YES
- NO

IF YOU DO need an oral medication for your upcoming MRI, did your ordering provider send in a prescription for your upcoming appointment? *

- YES
- NO - * If NO, please call your provider (910-332-3800) and request your prescription to be sent for pick up prior to your MRI.

****** EmergeOrtho IS UNABLE TO PROVIDE ANY MEDICATION AT THE TIME OF YOUR MRI. ******

Have you ever had an allergic reaction to MRI contrast? *

- YES
- NO

If YES, When and Where?

Are you currently being treated for Nephrogenic Systemic Fibrosis (NSF)? *

- YES

NO

Are you currently on dialysis? *

YES

NO

Have you had a contrasted MRI/CT in the last 72 hours? *

YES

NO

Female Patients: Do you have a menstrual cycle?

YES

NO

If YES, please type the date of your last menstrual cycle.

Female Patients: Is there any chance that you could be pregnant?

YES

NO

Female Patients: Are you breastfeeding? If YES, you will be provided education prior to your contrast-enhanced exam about breastfeeding after receiving contrast.

YES

NO

Please indicate if you have any of the following. If yes, please provide additional information.

Please check the box to indicate if you have any of the following. If yes, please provide additional information. *

- [ ] Implanted Cardiac Pacemaker or Cardioverter Defibrillator (ICD)
- [ ] Cochlear, otologic, or another ear implant
- [ ] Internal wires or electrodes
- [ ] Brain, spinal cord, bone fusion stimulator, or bone growth stimulator
- [ ] Implanted drug infusion pump or device
- [ ] Aneurysm clip(s)
- [ ] Any type of prosthesis (eye, penile, artificial limb, etc.)
- [ ] Eyelid spring or wire
- [ ] Swan-Ganz or thermodilution catheter
- [ ] Metallic stent, filter, or coil
- [ ] Surgical staples, clips, metallic sutures
- [ ] Shunt (glaucoma, spinal, intraventricular or brain)
- [ ] External fixation devices (headframes, halos, ankle monitor)
- [ ] Wire mesh implant from hernia repair
- [ ] Artificial heart valve

- [ ] Patch (pain, nicotine, glucose monitor)
- [ ] Swallowed a “CAMERA PILL” for an endoscopy procedure
- [ ] Orthopedic joint replacement or pins, screws, plates, rods, or sternal wires
- [ ] Removable dentures or partials
- [ ] Hearing aid(s)
- [ ] Tattoo or permanent makeup
- [ ] Body piercings (jewelry, studs, chains, micro dermal anchors, etc.)
- [ ] Radiation seeds or implants
- [ ] Tissue expander (breast)
- [ ] Acupuncture needles left in place
- [ ] None of the above

If you checked any boxes above, please provide additional information:

Pertinent history for today’s MRI

Did you sustain an injury to the area that we are scanning today?*

- ( ) YES
- ( ) NO

Have you had surgery on the affected area?*

- ( ) YES
- ( ) NO

Have you had any injections in the affected area?*

- ( ) YES
- ( ) NO

Please check the symptoms you are experiencing:*

- [ ] Pain
- [ ] Weakness
- [ ] Numbness
- [ ] Tingling
- [ ] Other:

How long have you been experiencing symptoms?*

Is there any other pertinent information you would like for us to know regarding the need for your MRI?

ATTENTION: You must check the box below in order to submit this form.

☐ I attest, as the Patient or Guardian, that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form regarding the MRI exam/procedure that I or the patient will undergo. *

Patient Signature: _____ Date: _____

MRI Technologist: _____ Date: _____