Brookings
HEALTH SYSTEM

300 22nd Avenue
Brookings, SD 57006
Phone: (605) 696-9000
Fax: (605) 696-8889

IMAGWOR

PATIENT LABEL

Magnetic Resonance (MR) Environment Screening Form for Individuals

Imaging Services

Date: _____ Exam: _____

Patient Name: _____ DOB: _____ Age: _____

Symptoms: _____

Physician: _____ **Height:** _____ **Weight:** _____

Warning: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e. MRI & MR angiography. **DO NOT ENTER** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI technologist or Radiologist before entering the MR system room.

THE MR SYSTEM MAGNET IS ALWAYS ON.

Circle **YES** for any condition which applies to you, **NO** to all others

Yes	No	Aneurysm clip(s)
Yes	No	Cardiac pacemaker or implanted defibrillator (ICD)
Yes	No	Electronic implant or device
Yes	No	Eyelid spring or wire
Yes	No	Magnetically-activated implant or device
Yes	No	Spinal cord stimulator / Neurostimulator
Yes	No	Internal electrodes or wires
Yes	No	Bone growth/bone fusion stimulator
Yes	No	Cochlear, otologic, or other ear implant, ear lens
Yes	No	Implanted drug infusion device

If Yes to the Above Questions - Patient unable to have MRI

Yes	No	Heart valve prosthesis
Yes	No	Any type of prosthesis (eye, penile, etc.)
Yes	No	Artificial or prosthetic limb
Yes	No	Metallic stent, filter, or coil, wire mesh
Yes	No	Shunt (spinal or intraventricular)

Yes	No	Tissue expander (e.g. breast)
Yes	No	Swan-ganz or thermo dilation catheter
Yes	No	Medication patch (nicotine, Fentanyl, etc.)
Yes	No	Surgical staples, clips or metallic sutures
Yes	No	Radiation seeds or implants
Yes	No	IUD, diaphragm, or pessary
Yes	No	Pregnant or nursing mother
Yes	No	Dentures, partial plates, braces
Yes	No	Tattoo or permanent makeup
Yes	No	Body piercing jewelry
Yes	No	Hearing aid
Yes	No	Breathing problems or motion disorder
Yes	No	Any allergies: _____
Yes	No	Surgery in the last 6 weeks
Yes	No	Vascular access port and/or catheter

Please list any prior surgery: _____

Have you experienced any problem related to a previous MRI exam or MR procedure ____yes ____no

Are you claustrophobic? ❑ Yes ❑ No If yes, do you have medication to take ordered by Physician? ❑ Yes ❑ No

Have you ever had an injury to your eyes involving a metallic object or fragment (metallic slivers or foreign body)?
❑ Yes ❑ No If yes, please describe: _____

Any incident involving a metallic object or foreign body (BB, bullet or shrapnel)? ❑ Yes ❑ No

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1. Have you had a prior X-ray, MRI or CT study relevant to the ordered exam? ..... ❑ Yes ❑ No

   If Yes: Body part Month/Year Hospital or Facility

2. Have you had a recent injury to the body part being scanned? ❑ Yes ❑ No Date of Injury: _____

3. Is your current weight greater than 550lb?.....❑ Yes ❑ No

4. Do you have a history of a reaction to a contrast dye used for an MRI? .....❑ Yes ❑ No

5. Do you have any orthopedic implants such as joint replacement, pin, screw, plate, etc?.....❑ Yes ❑ No
   If Yes , what location in your body: _____

The above questions have been answered accurately to the best of my knowledge and I understand the above information about this procedure.

Time:_____ Date:_____ Patient/Legal Representative Signature: _____

Relationship: _____

For Office Use Only:
Clinical Support Staff ❑ RN ❑ LPN ❑ Provider ❑ Scheduling ❑ MRI Technologist

Time:_____ Date:_____ Signature:_____

Time:_____ Date:_____ MRI Technologist Signature: _____