



MRI WORKSHEET

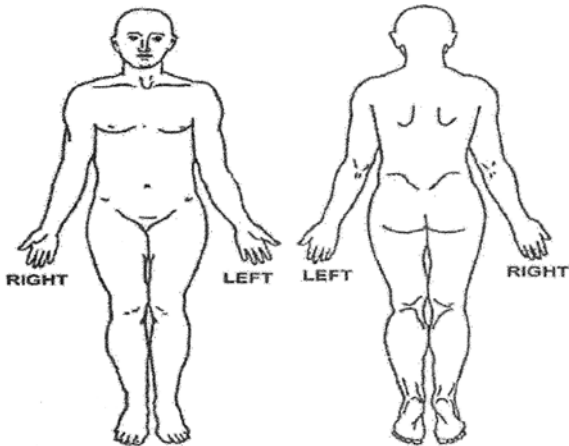
PATIENT INFORMATION

Name: _____ Age: _____ Sex: _____ MRN: _____

RADIOLOGIST: _____ Ordering Physician: _____

CURRENT SYMPTOMS: (Please describe the specific problems you are having at this time. If the symptoms are the result of an injury, please describe the injury):

How long have you had this problem? _____ Have you had surgery in this area? If yes, please describe:



MEDICAL HISTORY: _____

SURGICAL HISTORY: _____

CANCER HISTORY: _____

Please indicate the location of symptoms or injury on the drawing to the above.

PRIOR STUDIES: _____

(Technologist use only)

ALLERGIES: NKDA MRI contrast/ Dye Yes No Other _____

IV CONTRAST: OptiMark Omniscan Magnevist Eovist Multihance Other

Dose _____ cc Rate: _____ cc/sec Lot#: _____ Exp Date: _____

IV Site: RIGHT LEFT Circle one: Hand Wrist Antecubital Power PICC/Port

_____ gauge _____ Time # punctures _____ by _____

CONTRAST REACTION: Yes No Explanation: _____

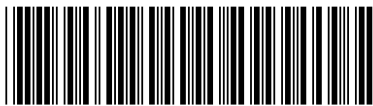
ORAL: _____ **TYPE:** _____ **AMOUNT:** _____

LABS: Creatinine: _____ mg/dl Lab or I-Stat GFR: _____ Date: _____ hCG: _____
(0.6 – 1.3 mg/dl) (circle one)

Hospital Use Only: Patient Location: ER Outpatient Inpatient-Room# _____

Comments: _____

Technologist: _____



MRI MEDICAL HISTORY AND SAFETY SHEET

PATIENT NAME: _____ DATE: _____ WEIGHT: _____ LBS.

DRUG ALLERGIES: _____ EXAM: _____ HEIGHT: _____

	YES	NO		YES	NO
Do you have a heart pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any implanted vascular stents?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any implanted devices?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an abdominal aneurysm repair?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had brain surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had or been treated for cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have heart disease or blood vessel disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a piece of metal embedded in your eye(s)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>	Have you taken any sedatives, alcohol, or other medications today to help you relax for this procedure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what? _____		
Have you ever had Lupus?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a reaction to MRI contrast in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any Electronic Implants?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain? _____		
Any history of sickle cell anemia?	<input type="checkbox"/>	<input type="checkbox"/>			
Is there a possibility you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>			
Are you breast feeding at this time?	<input type="checkbox"/>	<input type="checkbox"/>			

The following items can interfere with your MRI exam, cause injury to you, or be damaged by the MRI machine. Please check and inform the technologist if you have any of these items:

- | | | |
|--|-------------------------------|---|
| _____ Brain Aneurysm Clips | _____ IUD | _____ Breast Tissue Expanders |
| _____ Artificial Limbs | _____ Spinal Rods | _____ Body Piercing |
| _____ Removable Dental Work | _____ Hearing Aid(s) | _____ Cochlear implant |
| _____ Heart Pacemaker/ Defibrillator | _____ Artificial Heart Valves | _____ Implanted Medication Pump |
| _____ Inner Ear or Cochlear Implants | _____ Shrapnel/bullet/BB | _____ Penile implant |
| _____ V.P. Shunt (Brain shunt and tube) | _____ Wire Sutures | _____ Medication Patch |
| _____ Implanted Stimulator or Electrodes | _____ Tattoo Eyeliner | _____ Fractures with metal pins, rods, screws, nails or clips |

PLEASE REMOVE THE FOLLOWING:

ATM/Credit/Bank Cards, Barrettes or Hairpins, Buttons, Coins, Hearing Aids, Jewelry, Keys, Metal Hook Bras, Metal Zippers, Pens, Purses, Pocket Knives, Wallets, Watches, or any other Metal objects.

IMPORTANT

Please make sure that you have answered all of the questions as accurately as possible for your safety. If you have any questions, please ask the technologist before the exam begins.

I have informed the technologist that I do not have a pacemaker, aneurysm clips, or any metal embedded in my eyes.

Patient Signature: _____ Technologist's Initials: _____

