DIAGNOSTIC IMAGING CENTER

AT TEXAS NEUROLOGY

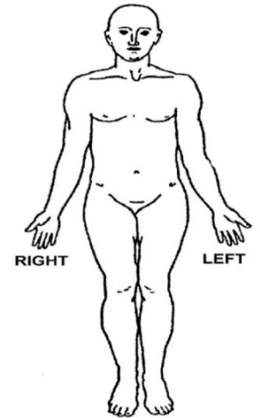
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure *(i.e. MRI, MRA, functional MRI, MR spectroscopy)*. DO NOT ENTER the MR room or MR environment if you have any question or concern regarding an implant, device, or object. The MR magnet is ALWAYS on. Please consult with the MRI Technologist/Radiologist BEFORE entering the MR room.

Patient Name	*Date of Birth*	*Height*	*Weight*	*Today's Date*
	/ /		lbs	/ /

Please indicate if you have any of the following, if yes, please specify:

Yes	No	
❑	❑	**Aneurysm clip(s)**
❑	❑	**Cardiac pacemaker**
❑	❑	**Implanted cardioverter defibrilator *(ICD)***
❑	❑	**Any medical implant or device** *Please specify:*
❑	❑	**Neurostimulation system**
❑	❑	**Spinal cord stimulator**
❑	❑	**Internal electrodes or wires** *Please specify:*
❑	❑	**Bone growth/bone stimulator**
❑	❑	Cochlear, otologic, outer ear implant *Please specify:*
❑	❑	Eyelid spring or wire
❑	❑	Any type of prosthesis *Please specify:*
❑	❑	Artificial or prosthetic limb
❑	❑	Metallic stent, filter, or coil *Please specify:*
❑	❑	Shunt *(Spinal or ventricular)*
❑	❑	Vascular access port and/or catheter
❑	❑	Radiation seeds or implants
❑	❑	Medication patch *(Remove before entering MR room)*
❑	❑	Any metallic fragment or foreign body *Please specify:*
❑	❑	Injury to eye from metallic fragment
❑	❑	Wire mesh implant
❑	❑	Tissue expander
❑	❑	Surgical staples, clips, or metallic sutures *Please specify*
❑	❑	Joint replacement
❑	❑	Bone/joint pin, screw, nail, wire, plate, etc.
❑	❑	IUD, diaphragm, or pessary *Please specify:*
❑	❑	Dentures or partial plates
❑	❑	Tattoo or permanent makeup
❑	❑	Any programmable implant or device *Please specify:*
❑	❑	Any other implant *Please specify:*
❑	❑	Body piercing jewelry *(Remove before entering MR system room)*
❑	❑	Hearing aid *(Remove before entering MR system room)*
❑	❑	Breathing problem or motion disorder
❑	❑	Claustrophobia *(Is medication needed?* ❑ Yes ❑ No) *If yes, please request a prescription from your physician.*

Please mark on the figure to the right the locations of any implant or metal on or inside of your body.



Do you have a history of:

Yes	No	
❑	❑	Kidney disease
❑	❑	Diabetes
❑	❑	Liver disease
❑	❑	Claustrophobia
❑	❑	Drug Allergy, Type:
❑	❑	Latex Allergy
❑	❑	Allergic reaction to MRI Contrast (Gadolinium based)

Female Patients

Yes	No	
❑	❑	Are you pregnant

❑ **I attest that the 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 about the information on this form regarding the MR procedure that I am about to undergo.**

OR

❑ **I attest that there have been no changes to the indications since I last completed this MR Screening Questionnaire.**

Previous Testing & Surgeries

	Body Part	Date	Facility
❑ MRI/MRA			
❑ CT/CAT SCAN			
❑ X-RAY			
❑ ULTRASOUND			
❑ NUCLEAR MEDICINE			
❑ OTHER			

IMPORTANT INSTRUCTIONS: Before entering the MR room or MR environment, you must remove ALL metallic objects including hearing aids, dentures, partial plates, keys, pager, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, belt, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clippers, tools, clothing with metal fasteners, and clothing with metallic threads.

Signature

Completed by: ❑ Patient ❑ Staff

❑ Other *(Please specify)*: ________________

Reviewed by: ________________

Please fax completed form to (214) 827-4343 or email to mrisupport@texasneurology.com