THE IMAGING CENTER - COOKEVILLE REGIONAL MEDICAL CENTER - MRI QUESTIONNAIRE PART 1

WARNING: Certain implants, devises or objects may be hazardous to you in the MRI environment or MR system room. Do not enter the MR environment room if you have any question or concern regarding an implant, devise, or object. Please indicate if you have any of the following.

- Cardiac Pacemaker
- Implanted cardiac defibrillator
- Aneurysm clip(s)/Coils
- Carotid artery vascular clamp
- Internal pacing wires
- Intravascular stents, filters, or coils
- Shunt (spinal or intraventricular)
- Penile Implant
- Any prosthesis or implant
- Implanted drug infusion device
- Bone growth/fusion stimulator
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- Any prosthesis or implant
- Bone growth/fusion stimulator
- Shunt (spinal or intraventricular)

Weight: ________ Height: ________ ARE YOU: Pregnant? Yes No

TAKING BIRTH CONTROL? Yes No

LAST MENSTRUAL CYCLE? ________

IT IS SAFE TO PROCEED WITH THE MRI EXAM: Yes No

Before your MRI you will be asked to change into CRMC clothing. All jewelry, body piercings, hair pins and metallic objects will need to be removed.

CLOTHES CONTAINING METAL FIBERS CAN BE DANGEROUS DURING MRI (MAGNETIC RESONANCE IMAGING), PUTTING METAL INTO THE SCANNER CAN ACTUALLY REACT OR HEAT UP AND BURN THE PATIENT.

Some clothing companies do not identify the metallic components of multipurpose fabrics incorporated in products ranging from athletic apparel like sports bras, yoga pants including socks and underwear. This makes it very hard for the MRI personnel to know if your clothing has any metal components.

If you fail to remove all your clothing and choose to wear additional items other than CRMC’s gowns, robes and or pants, you could be placing yourself at an increased risk of serious burns.

By signing this form you are acknowledging that you were informed of the possible dangers.

Patient Initial: ____________

Before your MRI you will be asked to change into CRMC clothing. All jewelry, body piercings, hair pins and metallic objects will need to be removed.

You are required to wear earplugs or earphones during the MRI examination.

Please mark on the figure, the location of any implant or metal inside of or on your body.

Office Staff:

Gaurdian/Patient Name (Print)

GUARDIAN/PATIENT SIGNATURE

SUBSEQUENT MRI: Patient has been screened/confirmed by Medical Records that no procedures have been performed and no medical devices have been implanted since the previous MRI on__________

IT IS SAFE TO PROCEED WITH THE MRI EXAM:

Exam: ____________________________ Date: ____________ Time: ____________

Caregiver/Nurse (print name): __________________________ Signature: __________________________

MRI Technologist: __________________________

Contrast: __________________________ Amount: __________________________

SUBSEQUENT MRI: Patient has been screened/confirmed by Medical Records that no procedures have been performed and no medical devices have been implanted since the previous MRI on__________

IT IS SAFE TO PROCEED WITH THE MRI EXAM:

Exam: ____________________________ Date: ____________ Time: ____________

Caregiver/Nurse (print name): __________________________ Signature: __________________________

MRI Technologist: __________________________

Contrast: __________________________ Amount: __________________________

CRMC STAFF ONLY

REVIEWED BY:

RN: __________________________ MRI Tech: __________________________

Date: ____________ Time: ____________ Date: ____________ Time: ____________

Procedure: __________________________

Contrast: __________________________ Amount: __________________________

Procedural: __________________________ Time Out: __________________________

Interpreter: __________________________ MRI Tech: __________________________
# PAIN

| Location: _____________________________ | Type: ______________________________ |
| Side: □ Left □ Right □ Bilateral     | How much does it hurt? Scale: 1-10 _______ |

# CANCER HISTORY

- □ Have you ever had Cancer? □ Yes □ No
- □ What type of cancer? ___________________
- □ Approx date of last evaluation for Cancer: ______________________

# GENERAL

- □ Bleeding Location: __________________
- □ Swelling Location: __________________
- □ Injury: □ Auto accident □ Fall □ Assault
- □ High Blood Pressure
- □ Diabetes
- □ Other, please specify: __________________

# NEUROLOGICAL

- □ Headaches □ Confusion □ Syncope
- □ Dizziness and/or Loss of Balance
- □ Visual Problems/Blurry Vision
- □ Weakness / Numbness / Tingling
- □ Location: ____________________________
- □ Are you? □ R Handed □ L Handed

# ABDOMINAL

- □ Nausea □ Vomiting □ Diarrhea
- □ Other stomach issues: ___________________
- □ Pain Location: ____________________________
- □ RUQ □ RLQ □ LUQ
- □ LLQ □ Epigastric □ Diffuse
- □ Pain Type: ____________________________
- □ Stabbing □ Dull □ Constant
- □ Intermittent □ Cramping

# RESPIRATORY

- □ Cough □ Shortness of Breath
- □ Chest Tightness □ COPD □ Asthma
- □ Do you smoke cigarettes? □ Yes □ No
- □ If yes, Packs/Day_____ Years smoking _____
- □ Chest Pain Location: _____________________
- □ □ Sternal/Precordial □ R □ L □ Diffuse
- □ Type: □ Stabbing □ Crushing □ Dull

# REQUIRED

- □ When did symptoms start? _________________
- □ Visit type: □ Initial □ Subsequent
- □ Date last visit for this problem? __________
- □ Previous Relevant Surgeries: ________________

- □ IV Contrast Type/Amount: __________________________
- □ Oral Contrast Type/Amount: _________________________
- □ Radiopharm Type/Amount: __________________________

- □ Patient unable to communicate

Information from: _________________________________________