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 system room if you have any question or concern regarding an implant, devise, or object. Please indicate if you have any of the following.

❑Yes ❑No **Cardiac Pacemaker**
❑Yes ❑No **Implanted cardiac defibrillator**
❑Yes ❑No **Aneurysm clip(s)/Coils**
❑Yes ❑No **Carotid artery vascular clamp**
❑Yes ❑No **Internal pacing wires** ***Initial*** ___
❑Yes ❑No **Intravascular stents, filters, or coils**
❑Yes ❑No **Shunt (spinal or intraventricular)**
❑Yes ❑No Penile Implant
❑Yes ❑No Implanted drug infusion device
❑Yes ❑No Stimulator: bone, spine, bladder
❑Yes ❑No Cochlea, otologic, or ear implant
❑Yes ❑No Heart valve prosthesis/Aortic Clip

❑Yes ❑No Artificial limb or joint
❑Yes ❑No Electrodes (on body, head, or brain)
❑Yes ❑No Vascular access port and/or catheter
❑Yes ❑No Swan-Ganz catheter
❑Yes ❑No Any implant held in place by a magnet
❑Yes ❑No Transdermal delivery system (Nitro)
❑Yes ❑No IUD or Diaphragm
❑Yes ❑No Tattoos and/or Tattooed makeup (eyeliner, lips, etc.)
❑Yes ❑No Body piercing(s)
❑Yes ❑No Any metal fragments
❑Yes ❑No Metal or wire mesh implants

❑Yes ❑No Wire sutures or surgical staples
❑Yes ❑No Harrington rods (spine)
❑Yes ❑No Metal rods in bones
❑Yes ❑No Joint replacement _____
❑Yes ❑No Bone/joint pin, screw, nail, wire, plate
❑Yes ❑No Hearing aid ***(Remove before MRI)***
❑Yes ❑No Dentures ***(Remove before MRI)***
❑Yes ❑No Metal Shavings in Eyes
❑Yes ❑No Allergies to medications
❑Yes ❑No Insulin pump / glucose monitor
❑Yes ❑No Other implant _____

Weight: _____ Height: _____ **ARE YOU: Pregnant? ❑Yes ❑No** **Taking birth control? ❑Yes ❑No** Last menstrual cycle?_____

Reviewed by PCA:_____ **Office Staff:** _____

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.**

Guardian/Patient Signature:_____

Guardian/Patient Print Name:_____

SUBSEQUENT MRI: Patient has been screened/confirmed that no procedures have been performed and no medical devices have been implanted since the previous MRI. Date:_____

IT IS SAFE TO PROCEED WITH THE MRI EXAM:

Exam: _____

Date: _____ Time: _____

Caregiver/RN (signature): _____

MRI Technologist (signature): _____

Contrast: _____ Amount:_____

SUBSEQUENT MRI: Patient has been screened/confirmed that no procedures have been performed and no medical devices have been implanted since the previous MRI. Date:_____

IT IS SAFE TO PROCEED WITH THE MRI EXAM:

Exam: _____

Date: _____ Time: _____

Caregiver/RN (signature): _____

MRI Technologist (signature): _____

Contrast: _____ Amount:_____

PATIENT ID STICKER

CRMC STAFF ONLY

REVIEWED BY:

RN: _____ **Date:** _____ **Time:** _____

MRI Tech: _____ **Date:** _____ **Time:** _____

Procedure:_____

Contrast: _____ Amount: _____

Interpreter_____ **Date:** _____ **Time:** _____

865-A

Cookeville Regional Medical Center

The Imaging Center Coding Information

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:_____

_____

PRE-OP TESTING

Type of surgery planned:

_____

NEUROLOGICAL

❑ Headaches ❑ Confusion ❑ Syncope

❑ Dizziness and/or Loss of Balance

❑ Visual Problems/Blurry Vision

❑ Weakness / Numbness / Tingling

Location: _____

Are you? ❑ R Handed ❑ L Handed

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

ABDOMINAL

❑ Nausea ❑ Vomiting ❑ Diarrhea

❑ Other stomach issues:

Pain Location: _____

❑ RUQ ❑ RLQ ❑ LUQ

❑ LLQ ❑ Epigastric ❑ Diffuse

Pain Type: _____

❑ Stabbing ❑ Dull ❑ Constant

❑ Intermittent ❑ Cramping

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 ID STICKER

❑ Patient unable to communicate

Information from: _____