Pembina High-Field MRI

AKA Direct Medical Imaging LLC

I. PATIENT INFORMATION DATE: ____________

PATIENT: ____
Last Name First Name

____
Sex Date of Birth

Patient Status: **Please Circle** Single Married Widowed

MAILING ADDRESS: ____
Address Prov Postal Code

____
City Email Address

PHONE: ____
Home Phone Cell Phone Emergency Phone

If patient is a Minor, Guardian: ______________________________
Last Name First Name Middle Name

REFERRING PHYSICIAN: ______________________________

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MRI SCREENING FORM

The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices or objects. Therefore, all individuals are requred to fill out this form BEFORE entering the MR environment or MR system room. Be advised, the MR system magnet is ALWAYS on.

Patient Name: ______________________________

Physician Name: ______________________________

Weight: ____________ Height: ____________ Age: ____________

Sex: ____________

Reason for Test/Area of Concern: ______________________________

Current Medications:

Known Drug Allergies: ______________________________

Known Allergies: ______________________________

Recent surgeries or invasive procedures: ______________________________

____

History of cancer, tumor or lymphoma? If yes, what type? ____________

Do you have history of kidney disease or dialysis? ____________

Have you experienced any problem related to a previous MRI examination? ______________________________

Have you had an injury to the eye involving a metalic object or fragment? ______________________________

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Do you have any of the following?

Cardiac Pacemaker/defribrillator?	Yes □	No □
Intracranial Aneurysm Clip	Yes □	No □
Stents/filters/shunts	Yes □	No □
Inner iear implant	Yes □	No □
Middle ear prosthesis	Yes □	No □
Carotid artery vascular clamp	Yes □	No □
Heart valve prosthesis	Yes □	No □
List type: ______		
Neurostimulater (TENS unit)	Yes □	No □
Implanted insulin pump	Yes □	No □
Penile Implant	Yes □	No □
Piece of metal in eye	Yes □	No □
Previously worked with metal	Yes □	No □
Orbital/eye implant	Yes □	No □
Shrapnel, bullets or BBs	Yes □	No □
If yes, where: ______		
Orthopedic pins, rods, screws, etc.	Yes □	No □
Post op staples	Yes □	No □
Any other implants	Yes □	No □
Artificial limb or joining prosthesis	Yes □	No □
Hearing aid/wig	Yes □	No □
Tattooed eyeliner/eye makeup	Yes □	No □
Dentures, retainers or braces	Yes □	No □
Possibility of pregnancy	Yes □	No □
Earings or hair pins	Yes □	No □
Breast feeding	Yes □	No □
Transdermal patches	Yes □	No □
Claustrophobic	Yes □	No □

I attest that the above information is correct to the best of my knowledge.

____

Patient Signature　　　　Technologist Signature　　　　Date: