M.R.I. QUESTIONNAIRE/CONSENT FORM

The following information is needed to schedule any in-house patient for an MRI examination. Please complete **ALL** information requested below. Upon completion, this form is to be faxed to the department 363-2765. Under no circumstances will a patient be scheduled for an MRI examination without completing/faxing the information requested below.

NAME: ______________________________ ROOM #: __________

D.O.B.: ______________ HEIGHT: ______________ WEIGHT: ______________

EXAM: ______________ DIAGNOSIS: ______________________________

ORDERING PHYSICIAN: ______________________________

Drug Reactions/Allergies: ______________________________

Does the patient have any of the items listed below? Please check appropriate boxes.

	YES	NO
Cardiac Pacemaker	☐	☐
Neurostimulator, other implanted electrodes, pumps, electronic devices	☐	☐
Brain Aneurysm Clip	☐	☐
Seizures	☐	☐
Heart Bypass/Valve Surgery	☐	☐
Shunt, Stent, Filters	☐	☐
If yes: location: __________ Date: __________		
Abdominal Aneurysm Clip	☐	☐
Eye Implants/Prosthesis	☐	☐
Hearing Aid (if yes, remove)	☐	☐
Dentures (if yes, remove)	☐	☐
Middle Ear Prosthesis	☐	☐
Metal Mesh/Wire Sutures	☐	☐
War Injury/Gunshot Wound	☐	☐

	YES	NO
Metallic Fragments in the head, eye or body	☐	☐
Known/Possible Pregnancy	☐	☐
IUD	☐	☐
Penile Prosthesis	☐	☐
Joint/Limb Replacements	☐	☐
Fractured bones w/metal	☐	☐
Harrington Rods/Spine Plates	☐	☐
Any Type of Prosthesis	☐	☐
Make-up W/Metallic Fragments	☐	☐
Wig	☐	☐
Medication Skin Patches	☐	☐
Tattoos/Body Piercings	☐	☐
Is the patient claustrophobic? Needs to be medicated.	☐	☐

Have you had any surgeries within the last two (2) months? ______________________________

Patient Condition (ie alert, oriented, stable, confused, etc.) ______________________________

Surgical History: ______________________________

____

Medications: ______________________________

____

I have read the above information and have answered the questions to the best of my knowledge. I hereby give my consent to have a Magnetic Resonance Imaging Scan. I have directed any questions to my physician.

______________________________ ______________

Signature/Title Caregiver Completing Form Date / Time

______________________________ ______________

Signature of Patient/Guardian Date / Time

I was informed of the importance of the use of earplugs during my procedure and understood and agreed thereof.

__________ (patient's initials) __________ (personnel's initials)

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PATIENT LABEL