



Beth Israel Deaconess Medical Center

Boston, MA 02215

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

MRI INPATIENT SCREENING QUESTIONNAIRE

Today's Date: ____/____/____

Patient's Name: _____

Weight: _____

Height: _____

An MRI involves the use of a very strong magnet. For your safety, the presence of certain metallic objects must be determined **before** you enter the exam room. Please place a check in the appropriate column for each item below and provide as much information as possible about any implanted devices.

	Yes	No		Yes	No	
1. Pacemaker / Pacer wires / Implantable defibrillator Date: ____/____/____ Make / Model #: _____			16. Are you wearing a patch that delivers medication?			
2. Intracranial or brain aneurysm clip (brain surgery) Date: ____/____/____ Make / Model #: _____			17. Do you have a history of difficult IV starts?			
3. Have you had an MRI before? If yes , did you receive a contrast injection?			18. Do you have an implanted port or indwelling catheter? Type: _____			
4. Have you had an MRI in the past 7 days? If yes , did you receive a contrast injection?			19. Implanted pump (insulin, pain med, chemotherapy) Type: _____ Location: _____			
5. Metallic heart valve or any metallic stents Date: ____/____/____ Make / Model #: _____			20. Are you on dialysis? If yes , how often: _____			
6. Bio or neurostimulator, electronic device or implant Date: ____/____/____ Make / Model #: _____			21. Please list all surgeries: _____ _____ _____			
7. Tattoo(s), Tattooed eyeliner Location: _____			22. Please check if you have any of the following medical conditions: <input type="checkbox"/> Asthma / Hay fever <input type="checkbox"/> Heart Disease <input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Pheochromocytoma <input type="checkbox"/> Sickle Cell Disease			
8. Body piercing If yes , location(s): _____				FEMALES ONLY:	Yes	No
9. Metal injury to the eye requiring medical attention If yes , date of injury: ____/____/____				23. Is there any possibility of pregnancy?		
10. Shrapnel (metal in body) Location: _____			24. Intrauterine Device (IUD) or Diaphragm Type or Model: _____			
11. Ear surgery or prosthesis Date: ____/____/____ Type or Model: _____			25. Pessary (in pelvis)			
12. Eye surgery or prosthesis Date: ____/____/____ Type or Model: _____			MALES ONLY:	Yes	No	
13. Limb or joint replacement or pinning Location: _____			26. Do you have a penile implant? If yes , make and model: _____			
14. Tissue expander (e.g. breast implant)						
15. Are you currently undergoing an endoscopy study that uses a small pill camera?						

MRI Staff will speak to you about the need for removing the following items:

Removable dental work | Eyeglasses | Wallet / keys | Watch / Jewelry | Credit and ATM (Automated Machine) cards | Hearing aids | Wigs / hairpieces or bobby pins

X _____ or **X** _____ and _____ / ____/____
Patient's Signature Person authorized to sign for patient Relationship to patient Date

X _____ / ____/____ _____
Nurse or Technologist Signature Print Name Date Time (24 hour)

HOSPITAL STAFF ONLY - Form re-certification for return to MRI during same admission:

No changes since original form completion Amendments to original form as follows:

X _____ M.D. / N.P. / P.A. _____ / ____/____ _____
Signature Print Name Date Time (24 hour)



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MED. REC. # _____

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Patient Identification

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Roughly 25% of attempts at MRI for patients in the hospital result in a non-diagnostic study. To help us serve the entire patient population safely and effectively, please respond to the questions below.



MF2063

Table with 3 columns: Question, Yes, No. Contains screening questions 27-37 regarding patient medical history and sedation requirements.

Comments:

X _____ M.D./N.P./P.A./R.N. Signature _____ Print Name _____ Pager # _____ Date ____/____/____ Time (24 hour) _____

IV Site: _____ IV Tech: _____ Gauge: _____ Scan Tech: _____