

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. DO NOT ENTER the MR system room or MR environment if you have any questions or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

logo1 **Magnetic Resonance (MR) Procedure Screening Form for Patients**

**MRN #: Location:**

**Patient Name: Email:**

**Sex: Weight: Age: DOB: Allergies:**

Please indicate if you have any of the following:

Yes No Aneurysm clip(s) Yes No Vascular access port and/or catheter

Yes No Cardiac pacemaker Yes No Shunt (spinal or intraventricular)

Yes No Implanted cardioverter defibrillator (ICS) Yes No Swan-Ganz or thermodilution catheter

Yes No Electronic implant or device Yes No Medication patch (nicotine, nitroglycerine)

Yes No Magnetically-activated implant or device Yes No Other implant

Yes No Neurostimulation system Yes No Wire mesh implant

Yes No Spinal cord stimulator Yes No Tissue expander (e.g. breast)

Yes No Internal electrodes or wires Yes No Surgical staples, clips, or metallic sutures

Yes No Bone growth/bone fusion stimulator Yes No Joint replacement (hip, knee, etc)

Yes No Cochlear, otologic, or other ear implant Yes No Bone/joint pin, screw, nail, wire, plate, etc.

Yes No Insulin or other infusion pump Yes No IUD, diaphragm, or pessary

Yes No Implanted drug infusion device Yes No Dentures or partial plated

Yes No Any type of prosthesis (eye, penile, etc) Yes No Tattoo or permanent makeup

Yes No Heart valve prosthesis Yes No Body piercing jewelry

Yes No Eyelid spring or wire Yes No Hearing aid (please remove before entering MR system room)

Yes No Artificial or prosthetic limb Yes No Pregnant

Yes No Metallic stent, filter, or coil Yes No Claustrophobia

Yes No History of Cancer Yes No Are you 60 or older

1. Have you had an injury to the eye involving a metallic object or fragment (e.g. metallic slivers, shavings, foreign body, etc.)?

If yes, please describe:

1. Have you ever been injured by a metallic object or fragment (e.g. BB, bullet, shrapnel, etc.)?

If yes, please describe:

1. Do you have kidney disease, kidney failure, kidney transplant, high blood pressure (taking medication) diabetes or seizures: (circle each)
2. Do you have history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye use for MRI,

CT or X-ray examination?

***Insurance disclaimer:*** Verification of the patient’s health insurance coverage is the patient’s responsibility. As a courtesy, Resurgens Imaging has contacted your insurance company to obtain benefit verification for your procedure today. Each verification received from the insurance company comes with a disclaimer: ***“Benefits received are only an estimate and is not a guarantee of payment. Benefits are based on the terms, conditions, exclusions, and eligibility of each plan. All benefits are subject to review upon submission of claim”.*** Resurgens Imaging has contacted your insurance company and determined benefits and estimated deposit for your procedure. I understand that any deposit paid today is not a guarantee of final payment and that it is only an estimate based on the information received from the insurance company and the contracted rate with our facility.

I have reviewed the above disclaimer Patients Initial

Surgeries:

For Office Use only:

I attest that the above information is correct to the best of my knowledge. I have read and understood the contents of this form.

Signature of Person completing Form: Date

Relative/Legal Guardian – Relationship:

Information Reviewed By: Technologist December *2015*