

MRI Medical/Surgical Safety data sheet

MIMA#:	Patient Name:	DOB:	Age:
Male/Female:	Height:	Weight:	Referring Physician:
Exam Date:	Exam Time:	Type of Exam:	

PLEASE FILL OUT ALL QUESTIONS EXCEPT FOR SHADED AREAS.

Y N Are you **claustrophobic**? Y N Did you take any sedation for this scan today?

Have you had or do you have any of the following:

- Y N **Cardiac Pacemaker or Defibrillator?**
- Y N **Brain Aneurysm Clip?**
- Y N **Brain surgery?** Please explain: _____
- Y N **Heart Surgery?** Please explain: _____
- Y N **Vascular/Arterial repair?** Please explain: _____
- Y N **Eye implants?** Please explain: _____
- Y N **Ear implants?** Please explain: _____
- Y N **Electronic Implants, Stimulators or Pumps including Penile Implants?** Please explain: _____
- Y N **Metal fragments in your eyes?** Please explain: _____
- Y N **Medication Patch?** Please explain: _____
- Y N **Body Piercing or Tattoos?** Location: _____
- Y N **Kidney Problems?** If yes, Taking **Feraheme?** : _____
- Y N Do you have **Removable Dental Work?**
- Y N Do you have **Hearing Aids?**
- Y N Personal history of **Cancer?** (Not family history): Please Explain: _____
- Y N **Mastectomy or Lymph Node** removal? Which side? _____
- Y N **Radiation Therapy or Chemo Therapy?** Please Explain: _____
- Y N Do you have a history of **Sickle Cell?**
- Y N Do you have a history of **Seizures?**
- Y N Do you have a history of **MS?**

Please list ALL prior surgeries: _____

Why are you having this exam today? _____

Female Patients: Date of last menstrual period: _____ Post Menopausal: Yes or No

Y N Any **chance** of pregnancy: Y N Are you **currently** breastfeeding?

Y N Prior MRI or CT When: _____ Where: _____

Y N Plain X-Rays of Region of Interest When: _____ Where: _____

I attest that the above information is correct to the best of my knowledge. I have been given the opportunity to ask questions regarding the information on this form as well as the MRI procedure that I about to undergo.

Patient Signature: _____ **Today's Date:** _____

MRI Technique: Patients over 40 years: **GFR_e:** _____ **GFR_c:** _____ **Creatinine:** _____ **Date Drawn:** _____

Contrast: Yes or No _____ mL Omniscan (GFR >90mL) Lot#: _____ Exp: _____
 _____ mL Multihance (GFR between 60-89mL) Lot#: _____ Exp: _____
 _____ mL Eovist Lot#: _____ Exp: _____
 _____ mL Multihance (GFR between 30-60mL) **Approved By:** _____ Lot# _____ Exp: _____

Post Exam Notes: _____

Screening Technologist: _____

Technologist Performing Exam: _____

Implant: _____

Manufacturer _____

Serial Number: _____

Date of Surgery: _____

Allergies: _____