

College Park Family Care Center Imaging Center

10600 Mastin

Overland Park, KS 66212

Phone: 913-956-4200 Fax: 913-338-1311

MRI PATIENT ASSESSMENT AND SCREENING FORM

Patient Name: _____ DOB: _____ Age: _____ Weight: _____ Sex: _____

Medical Record Number: _____ Date of Exam: _____ Time of Exam: _____

Exam Ordered: _____ Reason for Exam: _____

Ordering Physician: _____ Physician telephone: _____ and fax _____

PATIENT HISTORY

Metal, whether inside or outside your body can interfere with MRI imaging and in some instances can be dangerous to your health. To ensure your safety as well as a quality examination, it is important that you carefully complete this form with the guidance of a technologist. Any items marked yes are to be referred to the MRI department to determine if it is safe to have an MRI.

Please check below to see if any of the following apply to you.

- Yes No **Chance of Pregnancy LMP:** _____
- Yes No **Cardiac pacemaker/defibrillator**
- Yes No **Epicardial pacemaker wires**
- Yes No **Artificial Heart Valve**
- Yes No **Brain Surgery**
- Yes No **Aneurysm Clips**
- Yes No **Eye or Ear Surgery**
- Yes No **Metal Fragments in Eyes**
- Yes No **Gunshot wounds**
- Yes No **Stents, Coils, Filters or Wires**
- _____
- Yes No **Mechanical/electrical Implants or devices**
- _____
- Yes No **Magnetically Activated Implants or devices**
- _____
- Yes No **Bone or Joint pins or screws**
- Yes No **Artificial limb**
- Yes No **Hearing Aid**
- Yes No **Removable dental work**
- Yes No **Insulin/Drug Infusion Pump**
- Yes No **Underwire Bra**
- Yes No **Wig, Hairpins or Barrettes**
- Yes No **Permanent Tattoos**
- Yes No **Jewelry**
- Yes No **Metallic Eye Makeup**
- Yes No **Other metallic objects**
- Yes No **Patches for Medication**
- Yes No **Claustrophobia**
- Yes No **Allergy to Latex**

Patient's Surgical History:

Yes No History of Cancer _____

Yes No Diabetes

Yes No Kidney Problems

Have you had any other Radiology Exam for this problem? If yes what type: _____

For Office Use Only

Patient History/Clinical Symptoms:

Date of Injury: _____

I Contrast: _____ Amount: _____

Injection Site: _____ Technologist _____

Additional Technologist Notes:

I understand and have answered all of the above eligibility statements relating to potential risks.

Patient's Signature: _____ Date: _____

Technologist's Signature: _____ Date: _____