

Vancouver Coastal Health Authority

LGH  RH  UBCH  VGH

**MAGNETIC RESONANCE IMAGING (MRI)  
PATIENT SCREENING FORM**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

or PATIENT LABEL

Every patient scheduled for MRI **MUST** complete the following questionnaire prior to the being scanned. The technologist will be happy to answer any of your questions. **Please answer each question accurately and explain any marked "yes"**.

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Height \_\_\_\_\_ ft \_\_\_\_\_ in or \_\_\_\_\_ cm Weight: \_\_\_\_\_ kg or \_\_\_\_\_ lbs

<b>Do you have:</b>	<b>Yes</b>	<b>No</b>	<b>Unsure</b>	<b>If yes, explain</b>
Cardiac (Heart) Pacemaker or Wires (At any time in your life)				
Artificial Heart Valves				
Brain aneurysm clips				
Metal in your eyes (At any time in your life)				
Implanted Electrodes, Pumps or Catheters				
Neurostimulators				
Shrapnel, Bullets or other metal fragments				
Any Tattoos – including permanent make up				
Ear implants (Cochlear, Stapes) /Hearing Aid				
Orthopedic (Bone) Screws, Pins, Plates, Rods (If yes, state location)				
Breast tissue expander or other implants				
Prosthesis (Eye, Penile, Leg, Arm, Joint, etc.)				
Any Stents, Coils, or Filter in blood vessels				
Dentures, retainer, braces, magnetic implants				
Transdermal medication patches (Examples: Nitroglycerin for heart or Nicotine to stop smoking)				
Body Piercing other than earrings				
<b>Have you ever had surgery or operation on:</b>				
Brain, Eye, or Ear				
Heart				
Neck, Chest, or Back (Spine)				
Abdomen, Pelvis, Hips				
Arms and/or Legs				
Injection into a joint within the last 2 weeks				
<b>Are you:</b>				
Pregnant				
Claustrophobic				

Please remove all your jewelry, watch, credit cards, coins and other metallic items (earrings, hair clips, bobby pins, etc.). A MRI staff member will instruct you about securing your items prior to entry into the examination area. I have read and understand the entire contents of this form. I affirm that the above information is true to the best of my knowledge and I hereby consent to the MRI study

\_\_\_\_\_  
Signature of person completing this form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient if form not completed by patient

\_\_\_\_\_  
Review Date

\_\_\_\_\_  
Patient Initials

\_\_\_\_\_  
Signature of translator

MR Technologist Initials/Date

\_\_\_\_\_  
Date

If your MRI exam date occurs after the date the screening form was completed, you must review the screening form and alert the MR technologist of any changes. Please enter the date of review and your initials indicating confirmation of review.

## MRI Contrast Agent Questionnaire

Please answer the following questions:

Do you have:	Yes	No	Unsure
Any allergies?			
Renal problems or family history of such (Kidney problem, disease, condition)?			
Type I or II Diabetes?			
Liver transplant or currently on a waiting list for a liver transplant?			
History of stroke?			
Peripheral vascular disease (Problems with blood vessel circulation in arms or legs)			
Ischemic Cardiac disease (Heart problems such as blocked arteries, history of Heart attack)?			
Asthma? If yes, is your asthma currently active?			
Sickle Cell or Hemolytic Anemia?			
<b>Have you had:</b>			
Previous injection of MRI contrast?			
Did you have a reaction? If yes, describe what happened:			
<b>Are you:</b>			
On Dialysis?			
Pregnant and/or Nursing?			

Your doctors believe it is in your best interest to have an MRI (Magnetic Resonance Imaging) examination that includes the intravenous or IV injection (through an arm or hand vein) of a contrast agent containing gadolinium.

Gadolinium-containing contrast agents are given during MRI examinations to provide additional information regarding the presence and extent of inflammation, infection, or tumors, and to evaluate blood vessels. Gadolinium is considered to be quite safe, with a very low risk of minor allergic reactions, and an extremely low risk of serious allergic reactions. Should you have a reaction, there will be a Physician available and medication on hand to treat the reaction.

I have read and understand the above information, and have had an opportunity to have my questions answered.

I agree to receive an intravenous injection of a contrast agent containing gadolinium as part of the MRI examination to provide further diagnostic information.

\_\_\_\_\_  
Signature of person completing this form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient if form not completed by patient

\_\_\_\_\_  
Review Date

\_\_\_\_\_  
Patient Initials

\_\_\_\_\_  
Signature of translator

\_\_\_\_\_  
Date

MR Technologist Initials/Date

If your MRI exam date occurs after the date the screening form was completed, you must review the screening form and alert the MR technologist of any changes. Please enter the date of review and your initials indicating confirmation of review.