PRINT BLANK FORM | PRINT COMPLETED FORM AND RESET | RESET FORM

MUSC Health

ASCREENCRIT

RADIOLOGY / HEART AND VASCULAR CENTER (HVC)
MAGNETIC RESONANCE IMAGING (MRI)
MAGNETIC NAVIGATION SYSTEM (MNS)
PROCEDURE SCREENING FORM
Inpatient Only

☐ UNIVERSITY HOSPITAL RAD FAX: 2-1502
☐ ASHLEY RIVER TOWER RAD FAX: 6-7193

Form Origination Date: 1/05
Version: 6 Version Date: 3/08

This form may be completed on line. Tab or move cursor to text field and type in text.

For HIPAA Compliance reasons, this form IS NOT TO BE SAVED with patient information. Selecting the PRINT button will clear all information from the note.

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

WARNING: Certain implants, devices, or objects may be hazardous to you and / or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. **The MRI/MNS system magnet is ALWAYS on. If the patient has any implants, the information card must be attached to the screening form.**

Age _____ Height _____ cm Weight _____ kg Body part to be examined: _____

Please check Yes or No if the patient has any of the following:

Aneurysm clip(s)	☐ Yes	☐ No	☐ Unk
Cardiac pacemaker	☐ Yes	☐ No	☐ Unk
Implanted cardioverter defibrillator (ICD)	☐ Yes	☐ No	☐ Unk
Electronic implant or device	☐ Yes	☐ No	☐ Unk
Magnetically-activated implant or device	☐ Yes	☐ No	☐ Unk
Neurostimulation system	☐ Yes	☐ No	☐ Unk
Spinal cord stimulator	☐ Yes	☐ No	☐ Unk
Internal electrodes or wires	☐ Yes	☐ No	☐ Unk
Bone growth/bone fusion stimulator	☐ Yes	☐ No	☐ Unk
Cochlear, otologic, or other ear implant	☐ Yes	☐ No	☐ Unk
Insulin or other infusion pump	☐ Yes	☐ No	☐ Unk
Implanted drug infusion device	☐ Yes	☐ No	☐ Unk
Any type of prosthesis (eye, penile, etc.)	☐ Yes	☐ No	☐ Unk
Heart valve prosthesis	☐ Yes	☐ No	☐ Unk
Eyelid spring or wire	☐ Yes	☐ No	☐ Unk
Artificial or prosthetic limb	☐ Yes	☐ No	☐ Unk
Metallic stent, filter, or coil	☐ Yes	☐ No	☐ Unk
Shunt (spinal or intraventricular)	☐ Yes	☐ No	☐ Unk

Vascular access port and/or catheter	☐ Yes	☐ No	☐ Unk
Radiation seeds or implants	☐ Yes	☐ No	☐ Unk
Swan-Ganz or thermodilution catheter	☐ Yes	☐ No	☐ Unk
Medication patch (e.g., Nicotine, Nitroglycerin)	☐ Yes	☐ No	☐ Unk
Any metallic fragment or foreign body	☐ Yes	☐ No	☐ Unk
Wire mesh implant	☐ Yes	☐ No	☐ Unk
Tissue expander (e.g., breast)	☐ Yes	☐ No	☐ Unk
Surgical staples, clips, or metallic sutures	☐ Yes	☐ No	☐ Unk
Joint replacement (hip, knee, etc.)	☐ Yes	☐ No	☐ Unk
Bone / joint pin, screw, nail, wire, plate, etc.	☐ Yes	☐ No	☐ Unk
IUD, diaphragm, or pessary	☐ Yes	☐ No	☐ Unk
Dentures or partial plates	☐ Yes	☐ No	☐ Unk
Tattoo or permanent makeup	☐ Yes	☐ No	☐ Unk
Body piercing jewelry	☐ Yes	☐ No	☐ Unk
Hearing aid (remove before entering MR system room)	☐ Yes	☐ No	☐ Unk
Other implant _____	☐ Yes	☐ No	☐ Unk
Breathing problem or motion disorder	☐ Yes	☐ No	☐ Unk
Claustrophobia	☐ Yes	☐ No	☐ Unk
Dale flexible armboard for arterial line stability	☐ Yes	☐ No	☐ Unk

1. Has the patient had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☐ Yes ☐ No
   Date _____/_____/_____ Type of surgery _____
   Date _____/_____/_____ Type of surgery _____
2. Has the patient experienced any problem related to a previous MRI examination or MR procedure? ☐ Yes ☐ No
   If yes, please describe: _____
3. Has the patient had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ Yes ☐ No If yes, please describe: _____
4. Has the patient ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ Yes ☐ No
   If yes, please describe: _____
5. Does the patient have Sickle Cell Disease? ☐ Yes ☐ No
6. Has the patient ever had a reaction to an MRI or CT contrast medium? ☐ Yes ☐ No

For female patients:
7. Is the patient pregnant or experiencing a late menstrual period? ☐ Yes ☐ No
8. Is the patient currently breastfeeding? ☐ Yes ☐ No

Signature/credentials of person completing form: _____ Date _____ Time _____

Form completed / reviewed by Physician: _____ Pager ID _____

PRINT COMPLETED FORM AND RESET