

MRI Scan Date: _____

MRI Scan Time: _____

MRI Questionnaire

Phone: (603) 650-8445 or 650-5259

Fax: (603) 650-6353

Patient Name: _____

MRN: _____ DOB: _____

AGE: _____

To complete scheduling of MRI: Please call (603) 650-8445 or 650-5259.

Body Part to be examined: _____

Referring provider: _____ Office phone/Secretary: _____

Patient Data: Weight: _____

History / Questions to be answered: _____

MRI Risks (please ask the Patient ALL of the following questions):

- | | | |
|---|-----------------------------|------------------------------|
| Pacemaker/defibrillator (if so, the patient is not MRI compatible) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cerebral aneurysm clip (Make, Model, Year) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Vagal nerve stimulator | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cochlear implant | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Other implanted device | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Braces or permanent retainers | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Body piercings | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Ever worked with metal or have possibility of metal fragments in eyes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Shrapnel elsewhere in body (if so, what is it made of?) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Medication patch (such as a pain patch/smoking cessation, etc.) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Current pregnancy | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

If YES to ANY of these 4 questions, creatinine level needed within 3 months of scan:

- | | | | | |
|--|-----------------------------|-------------------------------|-----------------------------|-------------------------------------|
| History of diabetes in patient greater than 50y | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Patient's age greater than 70y | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| History of kidney failure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Is patient on dialysis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Claustrophobic | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Difficulty breathing or pain while lying flat | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Has patient ever required sedation or Anesthesia for MRI | <input type="checkbox"/> No | <input type="checkbox"/> Oral | <input type="checkbox"/> IV | <input type="checkbox"/> Anesthesia |
| Surgery on the area in question | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |

If yes, you may need to contact patient's Dialysis Center to set up a session within 3-4 hours of MRI.

Breast MRI Only Bra Cup Size: _____ LMP: _____

Current BCT/HRT: No Yes BCT/HRT stopped when: _____

Last Mammogram date: _____ Where: _____

Scheduler completing information: _____ Date: _____