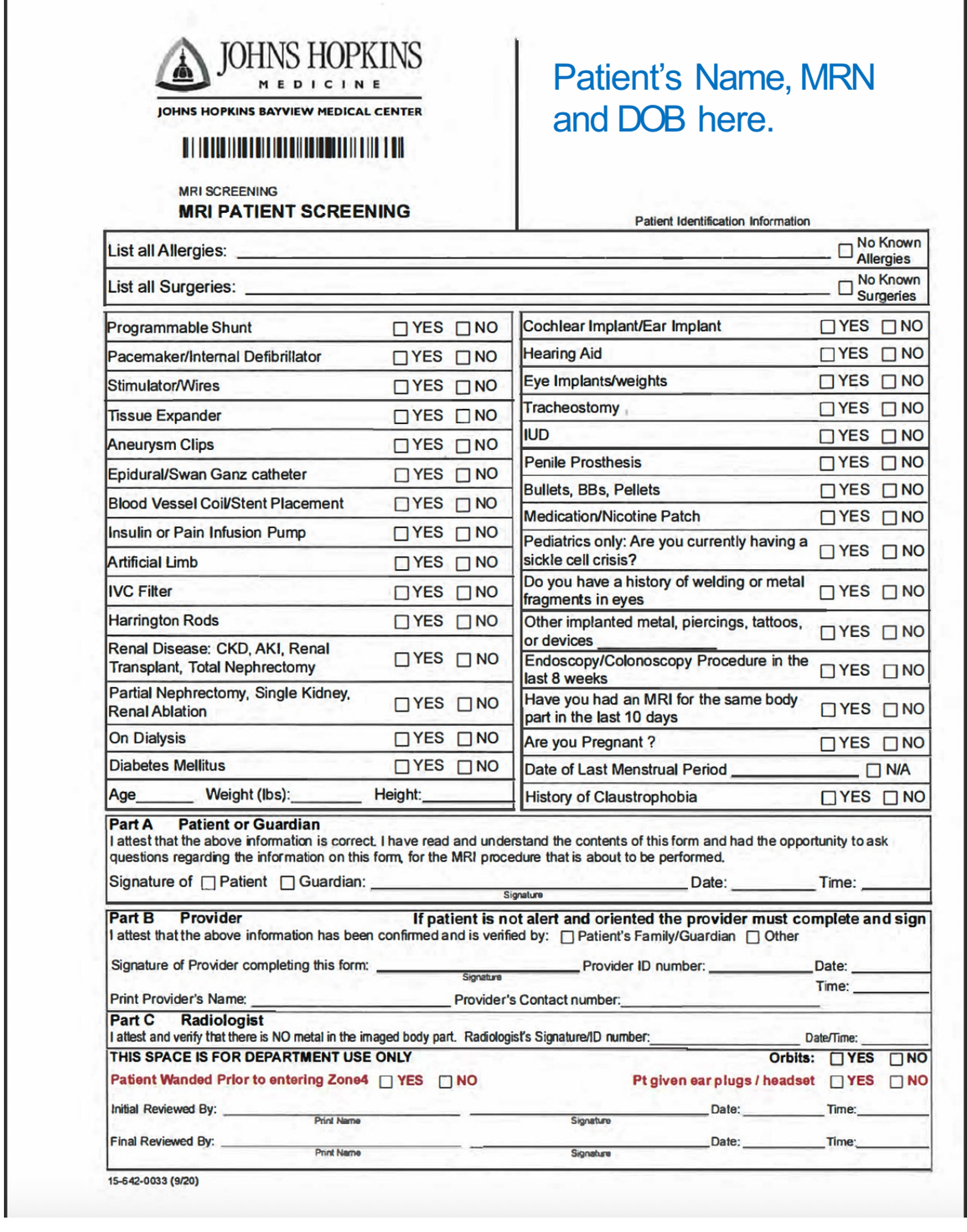
MRI Screening form

Complete it Contact MR techs if any answer is **Yes**.

Please bring it to MR techs for each scan.

- List of all surgeries and any implants.
- **Has the patient worked with metal**, cutting, grinding or pipe fitting, any accidents to the body, face or eyes with metal or glasses?
- **Does the patient wear a glucose monitor or infusion pump?**
  These devices are MR conditional or MR unsafe, meaning that we need to communicate with PI/physician about the feasibility of MR scan of the patient.
- **Does the patient have claustrophobia and need sedation to help them through their scan?** If yes, PI need to prescribe sedation and the patient brings it with him/her on the scan day.



JOHNS HOPKINS MEDICINE
JOHNS HOPKINS BAYVIEW MEDICAL CENTER

Patient's Name, MRN and DOB here.

MRI SCREENING
MRI PATIENT SCREENING

Patient Identification Information

List all Allergies: _____ ☐ No Known Allergies

List all Surgeries: _____ ☐ No Known Surgeries

Programmable Shunt	☐ YES ☐ NO	Cochlear Implant/Ear Implant	☐ YES ☐ NO
Pacemaker/Internal Defibrillator	☐ YES ☐ NO	Hearing Aid	☐ YES ☐ NO
Stimulator/Wires	☐ YES ☐ NO	Eye Implants/weights	☐ YES ☐ NO
Tissue Expander	☐ YES ☐ NO	Tracheostomy	☐ YES ☐ NO
Aneurysm Clips	☐ YES ☐ NO	IUD	☐ YES ☐ NO
Epidural/Swan Ganz catheter	☐ YES ☐ NO	Penile Prosthesis	☐ YES ☐ NO
Blood Vessel Coil/Stent Placement	☐ YES ☐ NO	Bullets, BBs, Pellets	☐ YES ☐ NO
Insulin or Pain Infusion Pump	☐ YES ☐ NO	Medication/Nicotine Patch	☐ YES ☐ NO
Artificial Limb	☐ YES ☐ NO	Pediatrics only: Are you currently having a sickle cell crisis?	☐ YES ☐ NO
IVC Filter	☐ YES ☐ NO	Do you have a history of welding or metal fragments in eyes	☐ YES ☐ NO
Harrington Rods	☐ YES ☐ NO	Other implanted metal, piercings, tattoos, or devices _____	☐ YES ☐ NO
Renal Disease: CKD, AKI, Renal Transplant, Total Nephrectomy	☐ YES ☐ NO	Endoscopy/Colonoscopy Procedure in the last 8 weeks	☐ YES ☐ NO
Partial Nephrectomy, Single Kidney, Renal Ablation	☐ YES ☐ NO	Have you had an MRI for the same body part in the last 10 days	☐ YES ☐ NO
On Dialysis	☐ YES ☐ NO	Are you Pregnant ?	☐ YES ☐ NO
Diabetes Mellitus	☐ YES ☐ NO	Date of Last Menstrual Period _____	☐ N/A
Age_____ Weight (lbs):_____ Height:_____		History of Claustrophobia	☐ YES ☐ NO

Part A Patient or Guardian
I attest that the above information is correct. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form, for the MRI procedure that is about to be performed.
Signature of ☐ Patient ☐ Guardian: _____ (Signature) Date: _____ Time: _____

Part B Provider **If patient is not alert and oriented the provider must complete and sign**
I attest that the above information has been confirmed and is verified by: ☐ Patient's Family/Guardian ☐ Other
Signature of Provider completing this form: _____ (Signature) Provider ID number: _____ Date: _____ Time: _____
Print Provider's Name: _____ Provider's Contact number: _____

Part C Radiologist
I attest and verify that there is NO metal in the imaged body part. Radiologist's Signature/ID number: _____ Date/Time: _____

THIS SPACE IS FOR DEPARTMENT USE ONLY **Orbits:** ☐ YES ☐ NO
Patient Wanded Prior to entering Zone4 ☐ YES ☐ NO Pt given ear plugs / headset ☐ YES ☐ NO
Initial Reviewed By: _____ (Print Name) _____ (Signature) Date: _____ Time: _____
Final Reviewed By: _____ (Print Name) _____ (Signature) Date: _____ Time: _____

15-642-0033 (9/20)

JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

MRI SCREENING

MRI PATIENT SCREENING

Patient Identification Information

List all Allergies: _____ ☐ No Known Allergies

List all Surgeries: _____ ☐ No Known Surgeries

Programmable Shunt	☐ YES	☐ NO	Cochlear Implant/Ear Implant	☐ YES	☐ NO
Pacemaker/Internal Defibrillator	☐ YES	☐ NO	Hearing Aid	☐ YES	☐ NO
Stimulator/Wires	☐ YES	☐ NO	Eye Implants/weights	☐ YES	☐ NO
Tissue Expander	☐ YES	☐ NO	Tracheostomy	☐ YES	☐ NO
Aneurysm Clips	☐ YES	☐ NO	IUD	☐ YES	☐ NO
Epidural/Swan Ganz catheter	☐ YES	☐ NO	Penile Prosthesis	☐ YES	☐ NO
Blood Vessel Coil/Stent Placement	☐ YES	☐ NO	Bullets, BBs, Pellets	☐ YES	☐ NO
Insulin or Pain Infusion Pump	☐ YES	☐ NO	Medication/Nicotine Patch	☐ YES	☐ NO
Artificial Limb	☐ YES	☐ NO	Pediatrics only: Are you currently having a sickle cell crisis?	☐ YES	☐ NO
IVC Filter	☐ YES	☐ NO	Do you have a history of welding or metal fragments in eyes	☐ YES	☐ NO
Harrington Rods	☐ YES	☐ NO	Other implanted metal, piercings, tattoos, or devices _____	☐ YES	☐ NO
Renal Disease: CKD, AKI, Renal Transplant, Total Nephrectomy	☐ YES	☐ NO	Endoscopy/Colonoscopy Procedure in the last 8 weeks	☐ YES	☐ NO
Partial Nephrectomy, Single Kidney, Renal Ablation	☐ YES	☐ NO	Have you had an MRI for the same body part in the last 10 days	☐ YES	☐ NO
On Dialysis	☐ YES	☐ NO	Are you Pregnant ?	☐ YES	☐ NO
Diabetes Mellitus	☐ YES	☐ NO	Date of Last Menstrual Period _____	☐ N/A	
Age_____ Weight (lbs):_____ Height:_____			History of Claustrophobia	☐ YES	☐ NO

Part A Patient or Guardian

I attest that the above information is correct. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form, for the MRI procedure that is about to be performed.

Signature of ☐ Patient ☐ Guardian: _____ Date: _____ Time: _____
Signature

Part B Provider **If patient is not alert and oriented the provider must complete and sign**

I attest that the above information has been confirmed and is verified by: ☐ Patient's Family/Guardian ☐ Other

Signature of Provider completing this form: _____ Provider ID number: _____ Date: _____
Signature
Time: _____

Print Provider's Name: _____ Provider's Contact number:_____

Part C Radiologist

I attest and verify that there is NO metal in the imaged body part. Radiologist's Signature/ID number:_____ Date/Time: _____

THIS SPACE IS FOR DEPARTMENT USE ONLY **Orbits:** ☐ YES ☐ NO

Patient Wanded Prior to entering Zone4 ☐ YES ☐ NO **Pt given ear plugs / headset** ☐ YES ☐ NO

Initial Reviewed By: _____ _____ Date: _____ Time:_____
Print Name Signature

Final Reviewed By: _____ _____ Date: _____ Time:_____
Print Name Signature