

MRI Screening Sheet

Patient Name _____ Phone Number _____ DOB _____
Referring Physician _____ Insurance _____
Appointment Date _____ Appointment Time _____ MRI Type _____
Is a precertification needed? Yes or No. If YES precert number _____
ID Number _____ PC# Verified _____

Eligibility Criteria

- | | | |
|--|---|---|
| 1. History of claustrophobia? | Y | N |
| 2. Less than 300 pounds? | Y | N |
| 3. Possibility of Pregnancy? | Y | N |
| 4. Pacemaker? | Y | N |
| 5. Heart valve prosthesis? | Y | N |
| 6. Defibrillator? | Y | N |
| 7. Coronary bypass clips? | Y | N |
| 8. Renal transplant clips? | Y | N |
| 9. Aneurysm clips? | Y | N |
| 10. Intracranial clips? | Y | N |
| 11. Other vascular clips? | Y | N |
| 12. Joint replacement? | Y | N |
| 13. Shrapnel? | Y | N |
| 14. Gunshot wound? | Y | N |
| 15. Hearing aids? | Y | N |
| 16. Middle ear prosthesis? | Y | N |
| 17. Orbital prosthesis? | Y | N |
| 18. Braces, dentures, retainers? | Y | N |
| 19. Wig? | Y | N |
| 20. Epilepsy? | Y | N |
| 21. IUD? | Y | N |
| 22. Pessary ring? | Y | N |
| 23. Neurostimulator (TENS unit)? | Y | N |
| 24. Shunt? | Y | N |
| 25. Body piercing? | Y | N |
| 26. Penile implant? | Y | N |
| 27. Orthopedic devices (pins, screws, plates)? | Y | N |
| 28. Tattooed eyeliner? | Y | N |
| 29. Exposure to metal fragments in eyes? | Y | N |
| 30. Nitroglycerin patch? | Y | N |
| 31. Sickle cell anemia? | Y | N |
| 32. Thalassemia? | Y | N |
| 33. Previous Surgery? | Y | N |
| If YES, what type? _____ | | |
| Why? _____ | | |
| 34. Allergies to medications? | Y | N |
| If YES, to what? _____ | | |

I certify that all questions were asked to patient and/or guardian at time appointment was made.

Appointment Scheduler Signature _____ Date _____

I certify that before placing patient in MRI unit all questions were once again asked to patient and/or guardian. Technologist Signature _____ Date _____

I the patient certify that all of the above questions were asked and that I have answered them honestly.

Patient's Signature _____ Date _____

I the guardian, or other legally responsible person if patient is a minor, disabled or otherwise able to give consent certifies that all of the above questions were asked and that I have answered them honestly.

Signature _____ Date _____