IOWA ORTHO
A CENTER OF EXCELLENCE®

OPEN MRI PROCEDURE SCREENING FORM

PLEASE LEAVE VALUABLES AT HOME.
WE ARE NOT RESPONSIBLE FOR LOST ITEMS.

Today's Date _____

Name _____ Phone _____

Sex _____ Age _____ Physician Ordering MRI _____

Date of Birth _____ Height _____ Weight _____

Area to be scanned _____

Describe Injury or Problem _____

Preferred testing location - ☐ Downtown Iowa Ortho ☐ No preference Other _____

Incorrect or falsified information can cause <u>serious injury</u> including <u>blindness</u>, <u>burns</u>, and/or <u>damage to implanted items</u>.

☐ Yes ☐ No Have you ever had an injury to the ***eye*** involving a metallic object (e.g., metallic slivers, shavings, foreign body, etc.)
Date of eye injury: _____ **Describe injury:** _____

☐ Yes ☐ No Have you ever been injured by any metallic foreign body (e.g., bullet, BB, shrapnel, etc.)?
Date of metallic injury: _____ **Describe injury:** _____

☐ Yes ☐ No Have you ever had a surgical procedure or operation of any kind?
If yes, please list all prior surgeries and approximate dates: _____
_____

☐ Yes ☐ No Have you had any surgeries or colonoscopies in the past 6 weeks?
If yes, please list: _____

☐ Yes ☐ No Do you have a history of cancer?
If yes, when, where, what type? _____

☐ Yes ☐ No Do you anticipate any problem with lying on your back for at least 45 minutes?

☐ Yes ☐ No Do you require assistance with any of the following: ambulation, walker, wheelchair or transferring from chair to table? ***Circle all that apply.***

☐ Yes ☐ No Do you have problems with claustrophobia (severe fear of small places)?

☐ Yes ☐ No Have you ever had an MRI?
If yes, when, where, what body part? _____
_____

☐ Yes ☐ No Has the body part to be scanned ever had an x-ray, MRI, CT, or any other test?
If yes, when, where? _____
_____

☐ Yes ☐ No Do you have a history of renal disease, seizure, asthma, allergic respiratory disease, diabetes, high blood pressure, anemia, or other blood disease? ***Circle all that apply.***

☐ Yes ☐ No Are you currently taking any blood thinners?

☐ Yes ☐ No Do you have any allergies to drugs, iodine, or shellfish?
If yes, please list: _____

☐ Yes ☐ No Have you ever had a reaction to a contrast medium used for MRI?

☐ Yes ☐ No Females only: Are you pregnant or do you suspect that you may be pregnant?

☐ Yes ☐ No Females only: Are you currently breast-feeding?

	Date	Location	Initials
LABS			
ORBITS			

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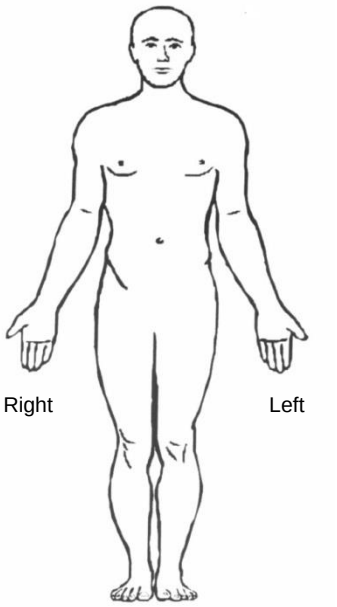
The following items may be hazardous or may interfere with MRI imaging by producing artifacts.

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

☐ Yes ☐ No Cardiac pacemaker
☐ Yes ☐ No Aneurysm clip(s)
☐ Yes ☐ No Implanted cardiac defibrillator
☐ Yes ☐ No Neurostimulator or biostimulator
☐ Yes ☐ No Implanted leads or pacing wires
☐ Yes ☐ No Hearing implant (including cochlear implant)
☐ Yes ☐ No Any type of coil, filter, stent, or shunt
Make and model: _____
☐ Yes ☐ No Swan-Ganz catheter or vascular access port
☐ Yes ☐ No Any type of electronic or magnetic implant or medication pump
☐ Yes ☐ No Any type of surgical hardware (plates, rods, etc.)
☐ Yes ☐ No Any type of prosthesis (heart, limb, penile, etc.)
☐ Yes ☐ No Eye implants or surgeries
☐ Yes ☐ No Any type of surgical clip or staples
☐ Yes ☐ No Halo vest
☐ Yes ☐ No Drug patch
☐ Yes ☐ No Body piercings
☐ Yes ☐ No Dentures
☐ Yes ☐ No Hearing aid
☐ Yes ☐ No Tattoos or permanent make-up*
☐ Yes ☐ No Any implanted birth control?
If yes, what type? _____
☐ Yes ☐ No Any other implanted item
Type: _____

Please mark on the drawing the location of your implants and/or metal injuries.



*A small percentage of patients with tattoos have experienced transient skin irritation in association with MRI. Therefore, you must decide if this slight risk warrants undergoing your examination.

PLEASE NOTE: IF YES TO ANY OF THE ABOVE, PLEASE LIST THE PHYSICIAN'S NAME AND ADDRESS BELOW.

_____

During your MRI exam, we use noise levels that some may find unacceptable and can temporarily affect your hearing. Iowa Ortho provides headphones or ear plugs for each patient.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form. Signature verifies understanding and correctness of information.

Patient's Signature _____ Date _____

If contrast with a gadolinium injection has been ordered, I hereby give my consent for this injection.
Patient's Signature _____ Date _____

Patient Review _____ Date _____