INTERMOUNTAIN
MEDICAL IMAGING

EMPI #_____

MRI SCREENING FORM

PATIENT NAME_____ Height_____ Weight_____DOB_____

What symptoms have prompted today's visit? _____

Yes No Cardiac pacemaker/Implanted Cardioverter Defibrillator (ICD)/Heart valve/Heart surgery:
Date/type _____

Yes No Shunts/Stents/Intravascular coil: **Date/type** _____

Yes No Ear or eye implants/surgery: **Date/type** _____

Yes No Injury to eye involving metal or metal shavings _____

Yes No Are you or do you suspect pregnancy? Or are you breast feeding? _____

Yes No Brain or brain aneurysm surgery: **Date/type** _____

Yes No Any electrical, mechanical, magnetic pumps, stimulators, and/or implants?
Date/type _____

Yes No Any body piercing jewelry?

Yes No Any breast tissue expanders?: **Date/type** _____

Yes No Shrapnel or metal fragments in skin or body?: Specify _____

Yes No Dentures/Hearing aid/Wig: **Please circle which applies**.

Yes No Any type of prosthesis (eye, penile, etc.)?: **Date/type** _____

Yes No History of cancer or tumors: _____

Yes No Radiation therapy/Chemotherapy: _____

Yes No Any allergies or any prior allergic reaction to MRI contrast/dye (Gadolinium)?: **Specify** _____

Yes No Respiratory, liver, or blood disorders: **Specify** _____

Yes No Any medication patches?: **Specify** _____

All other surgeries: Date/type _____

_____

Please list dates and locations of prior imaging related to today's exam: _____

_____

Yes No Patient is 60 or older

Yes No History of high blood pressure requiring medication

Yes No History of diabetes mellitus

Yes No History of renal disease including:

☐Dialysis ☐Kidney Transplant ☐Single Kidney ☐Kidney Surgery ☐History of Kidney Cancer

Office Use Only:
Creatinine level needed: YES NO
Creatinine_____Date_____
eGFR_____
☐22g 20g☐_____ by_____
IV site_____ Attempts_____

Patient or Guardian Signature _____ Date _____

IMI Tech Initials_____

ORIGINATED: December 2005
REVISED: 01/2007, 05/2007, 10/2012; 3/2014; 10/2014, 1/2015