MRI Pre-Screening Form

> *Please make every attempt to have the patient complete this form,*
> *prior to contacting Radiology to schedule the MRI scan*

MRI is a strong magnet environment that can be hazardous. If your patient has implanted devices like a pacemaker or any metal objects in their body it is essential to have this information prior to scheduling to **ensure the safety & timeliness** of the MRI scan. Lack of accurate information could result in canceling the MRI appointment on the day of the exam.

Date: _____   Patient's Name: _____   MRN # _____

Weight: _____   Height: _____   For Breast MRI scan: requires LMC if female of child bearing age _____

1. Does the patient have any kind of implants in their body?
   ✓ Pacemakers or pacemaker wires?   **Yes   No**

   ✓ Stimulators or stimulator wires?   **Yes   No**

   ✓ Pumps (any kind) or any implanted devices?   **Yes   No**

   ✓ Any type of shunts?   **Yes   No**

   – If yes, is the shunt a programmable shunt   **Yes   No**

   – Do you know the name and make of the shunt   _____

   ✓ Does the patient have any brain aneurysm clips?   **Yes   No**

   – If yes, was it done at Johns Hopkins   **Yes   No**

   ✓ Does the patient have any other metal or foreign objects in
   their body? Eye implants, tissue expander?   **Yes   No**

   – If yes, what type of implant & location   _____

   ✓ Has the patient ever had an allergic reaction to contrast that required

   medical treatment?   **Yes   No**

2. If any of the follow questions are answered Yes, then patient is required to obtain creatinine blood test within 30 days of their MRI or CT contrast enhanced exam.

We strongly recommend patients receive blood test prior to the day of their appointment. Patients can receive blood test in Express Testing same day, but should arrive at least 2-3 hours early to avoid cancelation of MRI scan.

   ✓ Any previous kidney surgery, i.e. kidney transplant, nephrectomy (removal of kidney)? **Yes   No**

   ✓ Any know kidney disease, such as kidney tumor, chronic kidney disease or renal   **Yes   No**
   insufficiency?

To be completed by the Radiology Scheduling Office
         Insert name of caller answering questions in display notes
         Scan back into Web X, if any modifications

Radiology Scheduler's name:_____ **Date:**_____ **Time:**_____