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?
     - 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 insufficiency? Yes      No

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:______________