IOWA ORTHO
BONE • MUSCLE • JOINT • SPINE

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 in the past 6 weeks?
If yes, please list: _____Date: _____

☐ Yes ☐ No Have you had a colonoscopy, endoscopy or pill cams in the last 8 weeks?
If yes, please list: _____Date: _____

☐ 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 any of the following: x-ray, MRI, CT, or any other test? ***Circle all that apply.***
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 Do you have any allergies to drugs or iodine?
If yes, please list: _____

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

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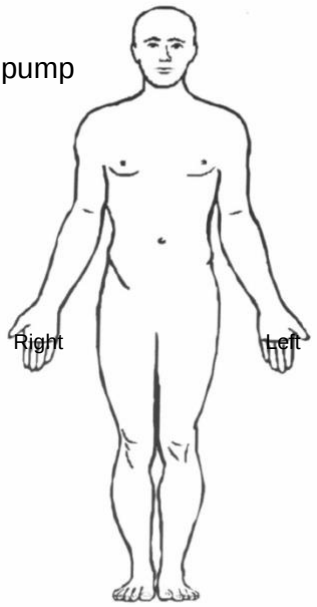
The following items may be hazardous or may interfere with MRI imaging by producing artifacts.

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

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

☐ Yes ☐ No Cardiac pacemaker, defibrillator or other cardiac implant (in place or removed)
☐ Yes ☐ No Aneurysm clip(s)
☐ Yes ☐ No Spinal cord stimulator, biostimulator or neurostimulator (in place or removed)
☐ Yes ☐ No Implanted leads or pacing wires
☐ Yes ☐ No Ear Surgery or Hearing implant (including cochlear implant)
If yes, when and what type? _____
☐ Yes ☐ No Any type of coil, filter, stent, or shunt
Make and model: _____
☐ Yes ☐ No Picc Line, Swan-Ganz catheter or vascular access port, etc.
☐ Yes ☐ No Any type of electronic, mechanical or magnetic implant or medication pump
☐ Yes ☐ No Any type of surgical hardware (plates, rods, spinal fusion, etc.)
☐ Yes ☐ No Any type of prosthesis (heart, valve, limb, penile, etc.)
☐ Yes ☐ No Eye implants or surgery: Lasik, Cataract, Artificial Eye, Other:
_____
☐ Yes ☐ No Any type of surgical clip or staples
☐ Yes ☐ No Drug patch
☐ Yes ☐ No Body piercings
☐ Yes ☐ No Dentures
☐ Yes ☐ No Hearing aid
☐ Yes ☐ No Tattoos or permanent/magnetic make-up*
☐ Yes ☐ No Any implanted birth control?
If yes, what type? _____
☐ Yes ☐ No Any other type of surgically implanted medical devices, removable medical devices or personal items not covered above?
If yes, 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. You will also be given MRI safe clothing to change into before your exam.

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 _____

Technologist Review _____ Date _____