S A R A

SOUTHERN ARIZONA RADIOLOGY ASSOCIATES

MRI SCREENING

Patient Name: _____ DOB: _____/_____/_____ Gender:_____

Weight: _____lbs Height: _____feet _____inches

Have you had any PRIOR EXAMS of the area we are scanning today? ☐ YES ☐ NO **Facility:_____**

Have you had surgery on the area we are scanning today? ☐ YES ☐ NO **When:____/____/_____**

Reason or symptoms for the exam today: _____

Do you have any of the following? (indicate YES or NO)

- Pacemaker or ICD (Implanted Cardiac Defibrillator) ☐ **YES** ☐ **NO**
- Brain Aneurysm Clip(s) (date implanted:___/___/___) ☐ **YES** ☐ **NO**
- Stimulator: neuro/spinal or DBS (Deep Brain Stimulator) ☐ **YES** ☐ **NO**
- Cerebrospinal Fluid Shunts (e.g. "Codman Certas TMS") ☐ **YES** ☐ **NO**
- Ear Implants (e.g. Cochlear, stapes or other) ☐ **YES** ☐ **NO**
- Hearing aids ***please remove prior to MRI** ☐ **YES** ☐ **NO**
- Implanted Drug Infusion pump/device (insulin or other) ☐ **YES** ☐ **NO**
- Implanted Vascular Access Port (e.g. "PortaCath","PowerPort") ☐ **YES** ☐ **NO**
- Eyelid ("Fatio") springs, Ocular magnets, Retinal Tack ☐ **YES** ☐ **NO**
- Intravascular or Cavitary Coils, Filters (if < 6 weeks) ☐ **YES** ☐ **NO**
- Breast Tissue Expander ***all models are unsafe** ☐ **YES** ☐ **NO**
- Penile Implant ("Duraphase" or "OmniPhase) ☐ **YES** ☐ **NO**
- Wound dressings containing ***SILVER*** (will cause artifacts) ☐ **YES** ☐ **NO**
- Metallic fragments (e.g. BB's, Steel shot, bullets or shrapnel) ☐ **YES** ☐ **NO**
- Metal slivers in eyes from welding or cutting metal ☐ **YES** ☐ **NO**
- Surgical hardware (e.g. screws, pins, artificial limbs/joints) ☐ **YES** ☐ **NO**
- Tattoos or permanent ink cosmetics ☐ **YES** ☐ **NO**
- Metallic body piercings or body jewelry ***please remove prior to MRI** ☐ **YES** ☐ **NO**
- Transderm patches (e.g. nicotine, nitroglycerine, "ActiPatch") ☐ **YES** ☐ **NO**
- History of Seizures or Epilepsy ☐ **YES** ☐ **NO**
- Diabetes, kidney problems or on Dialysis ☐ **YES** ☐ **NO**
- Asthma, respiratory disease or obstructive sleep apnea ☐ **YES** ☐ **NO**
- Personal history of Cancer, type _____ ☐ **YES** ☐ **NO**
- Allergy to CT, X-RAY (Iodine) or MRI (Gadolinium) contrast media ☐ **YES** ☐ **NO**
- Allergy to other medications, type _____ ☐ **YES** ☐ **NO**
- Allergy to Latex ☐ **YES** ☐ **NO**
- Claustrophobia ☐ **YES** ☐ **NO**
    - *if yes, did you take any SEDATIVES today ☐ **YES** ☐ **NO**
    - *if yes Name of Sedative:_____ Dose:_____ Time Taken:_____

"Southern Arizona Radiology Associates (SARA) and its assigned personnel have made a diligent and thorough attempt to identify any contraindications and to confirm the safety of any devices or implants for the purposes of this MRI procedure. After completing a thorough research the original manufacturer's recommendations have been followed as applicable. SARA is not responsible for any damage to any device or injury resulting from items not disclosed by the patient in the screening process".

"By my signature I attest that the above information is correct and that I have made full disclosure of any implanted device(s) or item(s) on my person to the best of my knowledge. I have read and understood the contents contained in this form and have had the opportunity to have all my questions answered to my satisfaction"

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_____ **Date: _____/_____/_____**

Patient signature (or legal guardian)