

Boulder MRI, Suite 105, 1000 W South Boulder Rd, Lafayette, CO 80026
Screening Form

Name:	DOB:	Height/Weight:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Describe symptoms you are experiencing:			
MRI TECHNOLOGIST CLINICAL NOTES (Patient to leave completely blank):			
Have you had surgery on the body part we are scanning? Y <input type="checkbox"/> N <input type="checkbox"/>	If yes, please describe:		Date of surgery:
Have you had a prior imaging study related to the scan you are having today? Y <input type="checkbox"/> N <input type="checkbox"/>	If yes, please describe: <input type="checkbox"/> MRI <input type="checkbox"/> CT <input type="checkbox"/> X-ray		Facility:
Have you ever been injured by a metallic object or foreign body (bullet, shrapnel, BB) or have had an injury to your eye involving a metallic object or fragment from grinding metal or welding (metallic slivers or shavings)? Y <input type="checkbox"/> N <input type="checkbox"/>			If yes, please describe:
Facility & Radiologist clearing orbital x-ray(s):			Date:
Do you have a history of asthma, respiratory disease, latex allergies, or an allergic reaction to a contrast medium used for an MRI, CT, or X-ray exam? Y <input type="checkbox"/> N <input type="checkbox"/>		If yes, please describe:	
Do you have any history of diabetes, cancer, or seizures? Y <input type="checkbox"/> N <input type="checkbox"/>		If yes, please describe:	
Are you claustrophobic? Y <input type="checkbox"/> N <input type="checkbox"/>	Medication type:	Time medication was taken:	
Are you taking medication to help you for this exam? Y <input type="checkbox"/> N <input type="checkbox"/>	Medication amount:	_____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
Any chance you could be pregnant? Y <input type="checkbox"/> N <input type="checkbox"/>	Are you breastfeeding? Y <input type="checkbox"/> N <input type="checkbox"/>		

Brain aneurysm clip(s)	Y <input type="checkbox"/>	N <input type="checkbox"/>	Intra-uterine device (IUD), diaphragm, or pessary	Y <input type="checkbox"/>	N <input type="checkbox"/>
Cardiac pacemaker or implanted cardioverter defibrillator	Y <input type="checkbox"/>	N <input type="checkbox"/>	Medication patch (Nicotine, Nitroglycerine)	Y <input type="checkbox"/>	N <input type="checkbox"/>
Magnetically-activated or Electronic implanted device	Y <input type="checkbox"/>	N <input type="checkbox"/>	Dentures or partial plates	Y <input type="checkbox"/>	N <input type="checkbox"/>
Cochlear, otologic, or other ear implants	Y <input type="checkbox"/>	N <input type="checkbox"/>	Radiation seeds or implants	Y <input type="checkbox"/>	N <input type="checkbox"/>
External hearing aids (Remove before entering MRI room)	Y <input type="checkbox"/>	N <input type="checkbox"/>	Metallic cervical fixation device	Y <input type="checkbox"/>	N <input type="checkbox"/>
Neurostimulation system or spinal cord stimulator	Y <input type="checkbox"/>	N <input type="checkbox"/>	Heart valve prosthesis, Swan-Ganz catheter, or thermolulution catheter	Y <input type="checkbox"/>	N <input type="checkbox"/>
Bone growth/bone fusion stimulator	Y <input type="checkbox"/>	N <input type="checkbox"/>	Surgical clips, staples, or metallic sutures	Y <input type="checkbox"/>	N <input type="checkbox"/>
Implanted insulin pump	Y <input type="checkbox"/>	N <input type="checkbox"/>	Implanted Orthopedic pins, screws, nails, clips, wires, plates etc.	Y <input type="checkbox"/>	N <input type="checkbox"/>
Metallic stents, shunts (spinal or intraventricular), filters, coils, etc.	Y <input type="checkbox"/>	N <input type="checkbox"/>	Joint replacement (hip, knee, etc.)	Y <input type="checkbox"/>	N <input type="checkbox"/>
Eyelid spring or wire	Y <input type="checkbox"/>	N <input type="checkbox"/>	Artificial or prosthetic limbs of any type (including eye, penile, etc.)	Y <input type="checkbox"/>	N <input type="checkbox"/>
Tissue expander (e.g., breast)	Y <input type="checkbox"/>	N <input type="checkbox"/>	Tattooed eyeliner or permanent makeup	Y <input type="checkbox"/>	N <input type="checkbox"/>
Internal electrodes/ or pacing wires	Y <input type="checkbox"/>	N <input type="checkbox"/>	Body piercing jewelry	Y <input type="checkbox"/>	N <input type="checkbox"/>

I attest that this information is correct to the best of my knowledge.

I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature of Person Completing Form:	Date:
Signature of MRI Technologist:	Date:



Important information regarding MRI Safety - The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. Therefore, all individuals are required to fill out this form BEFORE entering the MR environment or MR system room. Be advised, the MR system is ALWAYS on. Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, liter, nail clipper, tools, clothing with metal fasteners & clothing with metallic threads. You will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.