NORTH PITTSBURGH IMAGING SPECIALISTS

MRI EXAMINATION RECORD/CONSENT

PATIENT:______________________________________ BIRTHDATE:______________

OCCUPATION:__________________________ HT:_______ WT:_______ AGE:__________

CURRENT MEDS:____

ALLERGIES:____

ELIGIBILITY CRITERIA (Check Yes or No)	PATIENT			TECH	
MEDICAL SCREENING	Yes	No		Yes	No
Pregnancy or suspected pregnancy?					
Date of Last Monthly Period?					
Breastfeeding?					
Epilepsy or Seizures?					
History of Claustrophobia, pre-medication ordered by doctor?					
Any known history of renal failure/dialysis or Sickle Cell?					
Any cardiac problems?					
Any respiratory problems?					
Stroke?					
Cancer,Chemotherapy/Radiation Treatment?					
History of Diabetes/Renal disease?					
EXTREMELY IMPORTANT METAL SCREENING QUESTIONS					
Ever had head surgery? (aneurysm clips)					
Ever had heart surgery? (pacemaker, staples, clips, valves)					
Do you have a Vena Cava Filter? What kind of valve?					
Implanted infusion or stimulator devices?					
Ear Implants?					
Ever had metal in the eye?(Metalworkers/Grinder)					
Metallic IUD?					
METAL SCREENING					
Dentures, dental bridges, braces, or hearing aids?					
Eye lens implant or artificial eye?					
Is there any metal in/on your body?(Shrapnel, Bullets, B-B's)					
Other prior surgery? If yes, explain.					

IF PATIENT IS TO BE PREMEDICATED BY REFERRING PHYSICIAN FOR PAIN/ CLAUSTROPHOBIA, ETC., THEY MUST BE ACCOMPANIED BY SOMEONE TO DRIVE THEM HOME.

I understood and answered the above questions. **Patient's Signature/Date**	I have asked the above questions. **Screener's Signature/Date**
X	**X**

(TECH USE ONLY)HISTORY: