Capital Health
Trenton, NJ
MRI Procedure Patient Screening
(Fax to MRI @ RMC 609-278-6973
MRI @ HOPEWELL Outpatient 609-537-6476
MRI @ HOPEWELL Inpatient 609-537-6483)

Allergies: ☐ **No Known Allergies** ☐ If **Yes** please list _____ HEIGHT: WEIGHT: _____

Have you ever had a reaction to MRI or CAT Scan Contrast (dye)? ☐ Yes ☐ No ☐ Not known

Pertinent previous studies:

☐ X-ray ☐ CT Scan ☐ Ultrasound ☐ Nuclear Medicine ☐ MRI

When: _____ What body part: _____ Where performed: _____

The following items may be harmful to you during an MRI or may interfere with the MRI Examination.
Please check to indicate "Yes" or "No."

Y	N		Y	N	
☐	☐	A. Brain aneurysm surgery clip	☐	☐	E. Cochlear (ear) implant
☐	☐	B. Cardiac Pacemaker	☐	☐	F. Implanted cardiac defibrillator/internal electrodes, pacing wires
☐	☐	C. Neurostimulator/Biostimulator	☐	☐	G. Implanted insulin/drug infusion pump
☐	☐	D. Weight of more than 350 lbs.	☐	☐	H. Abdomen and/or hips diameter larger than 22 inches.

Please check to indicate "Yes" or "No:"

Y	N		Y	N		Y	N	
☐	☐	Hearing Aide	☐	☐	Surgical wire mesh	☐	☐	Intraventricular Shunt
☐	☐	Do you wear a brace?	☐	☐	Diaphragm or Pessary or IUD	☐	☐	Swan-Ganz catheter
☐	☐	Body Piercing	☐	☐	Artificial Heart Valve-Type_____	☐	☐	Diabetes
☐	☐	Hair weaves/wig/hair pins	☐	☐	Artificial limb/joint	☐	☐	Anemia/blood disease
☐	☐	Halo Vest	☐	☐	Spinal Fixation Device	☐	☐	Seizures
☐	☐	Artificial Eye	☐	☐	IV access port	☐	☐	Claustrophobia
☐	☐	Denture, false teeth or partial plate	☐	☐	Infusion Pump/ IV pump	☐	☐	Asthma/allergic respiratory disease
☐	☐	Tattoos or tattooed eyeliner	☐	☐	Intravascular coil, filter, stent	☐	☐	Renal Disease

Y	N		
☐	☐	Any types of surgical clip or staple (internal or external) Site_____	Type _____ When _____
☐	☐	History of Cancer?	Type _____
☐	☐	Any implant held in place by a magnet.	Type _____
☐	☐	Implanted orthopedic items (pins, rods, screws, etc.) Site_____	Type _____
☐	☐	Electronic or mechanical implant.	Type _____
☐	☐	Any other implanted item (penile implant, etc.). Site_____	Type _____
☐	☐	Have you ever been injured by any metallic foreign body (bullet, shrapnel, etc.)?	Type _____
☐	☐	Have you ever had an injury to the eye involving a metallic object? ********X-Ray of Orbits for MRI must be ordered if yes for metal in eyes***	
☐	☐	Are you pregnant or do you suspect that you are pregnant?	
☐	☐	Are you breast-feeding?	
☐	☐	Is a medication patch worn? ****(Medication patch to be removed prior to MRI)****	

Surgical History and Dates: (include stent, implants, etc)

_____

Y	N	
☐	☐	Is the patient confused or combative? If yes, is there medication ordered?: _____
☐	☐	Is the patient experiencing any pain? If yes, is there pain management protocol in place?: _____
☐	☐	Is the patient claustrophobic? If yes, obtain order for medication?.
☐	☐	Is the patient on isolation? If yes, what type: _____
☐	☐	Does the patient require cardiac monitoring?

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 the form.

Signature of Patient, Relative or Guardian _____ Relationship_____ Date: _____ Time_____

Reviewed by Nurse: _____ Date: _____ Time: _____

Reviewed by MRI Technologist: _____ Date: _____ Time: _____

*** If patient unable to do screening form. Information obtained from: _____