RALEIGH NEUROSURGICAL CLINIC INC.
5838 SIX FORKS ROAD, SUITE 100
RALEIGH, NC 27609
919-785-3400

MRI Patient Screening Form

PATIENT INFORMATION

Patient Name ____________________

Date of Birth ____________________ Height __________ Weight __________

Reason for Exam: ____________________

Date of Exam ____________________

☐ Yes ☐ No Previous imaging of body part being scanned today? Where? ____________________

PATIENT HISTORY

Do you have any of the following:

☐ Yes ☐ No **Pacemaker or Defibrillator**
☐ Yes ☐ No Mechanical Heart Valve
☐ Yes ☐ No Stents
☐ Yes ☐ No Vena Cava Umbrella/ IVC Filter
☐ Yes ☐ No **Neurostimulator**/External Electrodes
☐ Yes ☐ No Brain, Eye or Ear Surgery
☐ Yes ☐ No **Brain Aneurysm** Clips
☐ Yes ☐ No Programmable Shunt
☐ Yes ☐ No Removable Hearing Aid/**Cochlear Implant**
☐ Yes ☐ No Removable Dental Work
☐ Yes ☐ No Infusion Pump
☐ Yes ☐ No Wound Dressing (i.e. Acticoat 7)
☐ Yes ☐ No **Breast Tissue Expanders**
☐ Yes ☐ No Tattoos and/or Body Piercings
☐ Yes ☐ No Small Bowel **Camera Capsule** Study*
☐ Yes ☐ No EGD/Colonoscopy with Clips*
☐ Yes ☐ No **Metallic Gunshot wound, shrapnel, BBs***
Metal fragments in eyes or body (Injury to eye involving metal)

Do you have any of the following Medical Conditions?

☐ Yes ☐ No Claustrophobia
☐ Yes ☐ No Diabetic ☐ **Insulin pump**
☐ Yes ☐ No History of Kidney Disease
☐ Yes ☐ No Dialysis/Kidney Failure
☐ Yes ☐ No History of Liver Disease
☐ Yes ☐ No Iron deficiency treated with Feraheme
☐ Yes ☐ No Medication Skin Patches
☐ Yes ☐ No Latex Allergy
☐ Yes ☐ No Hypertension (High Blood Pressure)
☐ Yes ☐ No History of Cancer Type ____________________
Radiation Therapy/Chemo ____________________

>>> **Women:** Last Menstrual Period ____________________
☐ Yes ☐ No Pregnancy* Weeks

List All Surgeries ____________________
____
____
____

***Supervising Radiologist Approval:** ____________________ **Date:** __________

List All Medications
1 ____________________
2 ____________________
3 ____________________
4 ____________________
5 ____________________
6 ____________________

Please List All Medication Allergies
1 ____________________
2 ____________________
3 ____________________
4 ____________________
5 ____________________
6 ____________________

****** I acknowledge the above information is true and accurate to the best of my knowledge***

Patient Signature X ____________________ Date: ____________________
(Parent or Guardian if patient is a minor or incapacitated)

TECHNOLOGIST SECTION

EXAM ____________________ **Medical Record #** ____________________

CONTRAST
Your physician or radiologist may deem it necessary to have an IV injection of a contrast agent containing gadolinium to improve the quality of your MR examination. I understand the use of contrast and have had all my questions answered.

☐ History of previous Gadolinium reaction

X ____________________
Patient Signature (Parent or Guardian if patient is a minor or incapacitated)

Contrast Name ____________________
Amount ____________________
Lot ____________________ Exp ____________________
Injection Site ____________________
Device Used ____________________
Tech Initials

eGFR: __________ iSTAT result: __________
☐ Post injection instructions given
☐ Yes ☐ No Barriers to Learning, Please explain: ____________________
____

Tech Comments: ____________________
____

Tech attest information reviewed ____________________ Tech Signature ____________________