GRAND VIEW HEALTH
700 Lawn Avenue
Sellersville, PA 18960

OUTPATIENT MRI SCREENING QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
Please complete and print MRI Screening Form or forward to MRI@gvh.org

Name *(Last, First, M.I.)*: _____ DOB: _____

Height: _____ Weight: _____ Reason for MRI (Symptoms?): _____

Prior Imaging on this Body Part? Yes No If yes, where, when? _____

Prior Surgery on this Body Part? Yes No Please provide all out of network comparison reports & CD Images to minimize any result delays.

Any chance of Pregnancy? Yes No Date of Last Menstrual Period: _____
Breast MRI Imaging recommended to be performed between 7 - 14 days after onset of LMP.

Injury to Eye with Metal? Yes No If yes, was metal removed? Yes No

Recent X-ray of Eyes? Yes No

Do you have Kidney Disease? Yes No If yes, are you on Dialysis? Yes No

Are you Diabetic? Yes No If yes, do you wear a glucose monitor? Yes No

Any history of Cancer? Yes No

Have you had a reaction to MRI contrast (Gadolinium) in the past? Yes No

If you have a Port, would you like it accessed for the contrast injection? Yes No

Claustrophobic? Yes No If yes, contact your physician for sedation.

SURGICALLY IMPLANTED MEDICAL DEVICES

Do you CURRENTLY HAVE or HAVE YOU EVER HAD any of the following:
(Please provide Implant Card Documentation)

Device Name	YES	NO
Cochlear (ear) implant		
Abandoned Leads (from a pacemaker/stimulator)		
Breast Tissue Expander		
Shunt (Programmable Dial not performed at GVH)		
Any electronic, mechanical or magnetic implant		
Eye or Eyelid Implant		
Cardiac Pacemaker/Defibrillator		
Aneurysm/embolization clips or coils		
Neurostimulator, diaphragmatic stimulator, deep brain stimulator, vagus nerve stimulator, bone growth stimulator, spinal cord stimulator, or any biostimulator		
Internal electrodes or wires		
Implanted drug pump		
Coil, filter or stent		
Artificial heart valve		
Loop Recorder		
Penile Implant		
IV access port		
Clips/Staples		
Artificial Limb		
BBs, Bullets or Shrapnel		
Bladder pacemaker		
Intracranial pressure monitor (BOLT)		

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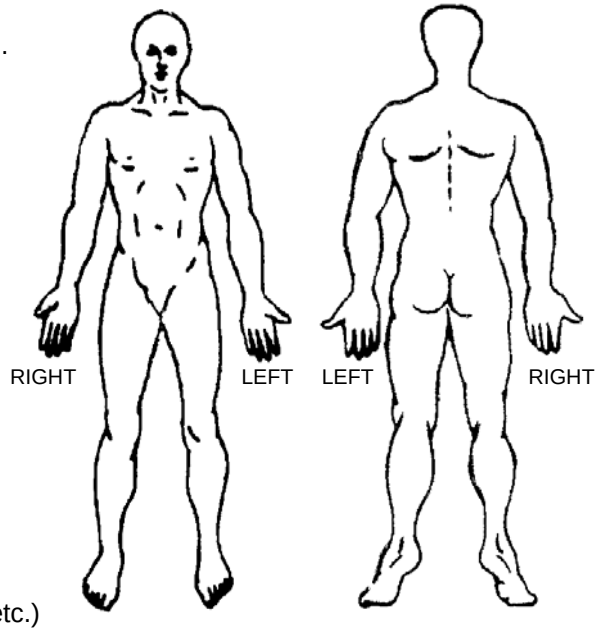
Device Name (continued)	**YES**	**NO**
Magnetically Activated Implant		
Swan-Ganz or Thermodilution Catheter		
Magnetic dentures		

Any other implants? _____

Please use the chart to indicate the areas of your pain and any regions where the pain radiates.



We will provide hearing protection. The scanner can affect your hearing.

Before Entering the Scan Room, Please Remove:

- Insulin Pump / Glucose Monitor
- Hearing Aids
- Medication Patches
- Dentures (if having brain MRI)
- External cardiac monitor (or any monitor outside the body)
- Magnetic Eyelashes, makeup or nail polish
- Suspenders
- All jewelry and hairpins
- Watches
- Fitbits
- Oura ring
- Metallic clothing (Tommy Copper, Lululemon, Copper Braces, etc.)
- All items in pockets (wallet, cards, keys, phone, change, pocket knife, etc.)

The above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the chance to ask questions about the information on this form and about the MR procedure that I am about to undergo.

Date: _____ Time: _____ Signature of Person Completing Form: _____

Form completed by: Patient | Relative Nurse

Print Name: _____ Relationship to Patient: _____

Yes No Patient screened with ferromagnetic detector

Yes No eGFR indicated for contrast

eGFR value: _____ Results date: _____

Form information reviewed by: MRI Technologist | Nurse Radiologist Other: _____

Print Name: _____ Signature: _____