LAFAYETTE IMAGING, LLC

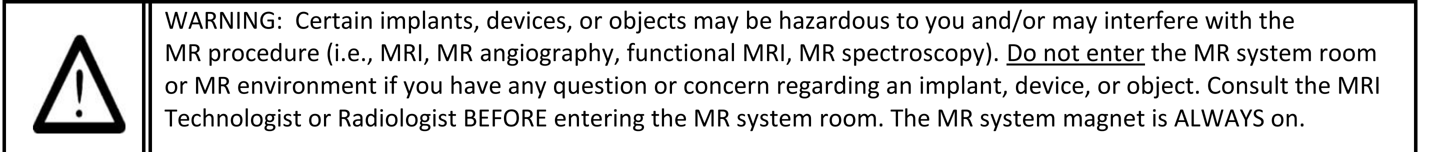
MRI Patient Screening Form

Last Name____________________________________First____________________________________Middle__________

Date of Birth___________________________ Sex: M F (circle one) Phone _________________________________

Address____City______________ State____ Zip Code_______

Ordering Physician_______________________________________ Todays Date ______________________________



WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please check yes or no to the following:

Yes	No	Aneurysm clip(s)
Yes	No	Cardiac pacemaker
Yes	No	Implanted cardioverter defibrillator (ICD)
Yes	No	Electronic implant or device
Yes	No	Magnetically-activated implant or device
Yes	No	Neurostimulation system
Yes	No	Spinal cord stimulator
Yes	No	Internal electrodes or wires
Yes	No	Bone growth/bone fusion stimulator
Yes	No	Cochlear, otologic, or other ear implant
Yes	No	Insulin or other infusion pump
Yes	No	Implanted drug infusion device
Yes	No	Any type of prosthesis (eye, penile, etc.)
Yes	No	Heart valve prosthesis
Yes	No	Eyelid spring or wire
Yes	No	Artificial or prosthetic limb
Yes	No	Metallic stent, filter, or coil
Yes	No	Shunt (spinal or intraventricular)
Yes	No	Vascular access port and/or catheter
Yes	No	Radiation seeds or implants
Yes	No	Swan-Ganz or thermodilution catheter
Yes	No	Medication patch
Yes	No	Any metallic fragment or foreign body
Yes	No	Wire mesh implant
Yes	No	Tissue expander (e.g., breast)
Yes	No	Surgical staples, clips, or metallic sutures
Yes	No	Joint replacement (hip, knee, etc.)
Yes	No	Bone/joint pin, screw, nail, wire, plate,
Yes	No	IUD, diaphragm, or pessary
Yes	No	Dentures or partial plates
Yes	No	Tattoo or permanent makeup
Yes	No	Body piercing jewelry
Yes	No	Hearing Aid (Remove)
Yes	No	Other implant _____________________
Yes	No	Breathing problem or motion disorder

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

Signature of Person Completing Form: ____ Date _____/_____/_____

Signature

Form Completed By: Patient Relative _______________________________________ __________________________

Print name Relationship to patient

MRI Technologist Signature: ____

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