SIKER | MEDICAL
IMAGING AND INTERVENTION

www.sikerimaging.com | 877 SIKER MR (877.745.3767)
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9775 SW Wilshire Street, Suite 100 • Portland, OR 97225 | T 971.888.5327 | F 971.200.2718

MRI SCREENING FORM

MR#: _____ **Exam Date:** ____/____/____

Full Name: _____ **D.O.B:** ____/____/____ **Height:** ___ft ___in **Weight:** ____lbs

It is vital that you provide the most accurate information possible when filling out this form. Although it isn't considered harmful, MRI uses very powerful radio frequency waves which can cause injury or death to those who have metal of particular varieties in their body.

❍YES ❍NO Have you had prior imaging studies on the area being examined today?

If yes, do you have a copy? ❍YES ❍NO

Where? _____ When? _____ Type? _____

❍YES ❍NO Do you have a cardiac pacemaker or defibrillator?

❍YES ❍NO Have you had any heart surgery or procedure?

If yes, when? Where? _____

❍YES ❍NO Have you had any brain surgery or procedure?

If yes, when? Where? _____

Name of Physician/Surgeon: _____

❍YES ❍NO Do you have any implanted coils, filters or stents?

If so, please provide model and implant card: _____

❍YES ❍NO Do you have any eye implants?

If so, please provide model and implant card: _____

❍YES ❍NO Have you had any incident of metal in your eyes (ex. welding)?

If so, was it removed by a doctor? YES NO

❍YES ❍NO Do you repeatedly get metal in your eyes? YES NO

❍YES ❍NO Have you had any eye surgery or procedure?

If yes, when? Where? _____

Name of Physician/Surgeon: _____

❍YES ❍NO Have you had any ear surgery or procedure?

If yes, when? Where? _____

Name of Physician/Surgeon: _____

❍YES ❍NO Do you have any allergies to medications?

Please List: _____

❍YES ❍NO Do you have an implanted stimulator/magnetic implants?

If so, please provide model and implant card: _____

❍YES ❍NO Do you have an IUD, pessary, or diaphragm?

If so, type of IUD: _____

❍YES ❍NO Are you wearing hearing aids? (They'll need to be removed prior to exam.)

❍YES ❍NO Are you wearing removable dental implants? (Please remove if possible.)

❍YES ❍NO Are you Pregnant?

If so, how many weeks? _____

❍YES ❍NO Do you have breast tissue expanders/implants?

If so, type: _____

❍YES ❍NO Do you have any screws, pins, orthopedic implants, or joint replacements?

If so, type: _____

❍YES ❍NO Are you wearing any medicated skin patches? _____

❍YES ❍NO Do you have any other metal or implanted devices? _____

If so, please provide model and implant card: _____

Patient or responsible party signature: _____ **DATE:** _____/_____/_____

Signature of employee clearing patient for MRI: _____

Please remove all metallic objects before entering the MRI room including hearing aids, beeper, cell phone, keys, eyeglasses, hair pins, barrettes, jewelry (including body piercing jewelry), watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, steel-toed boots/shoes, and tools. Loose metallic objects are especially prohibited in the MRI environment. Please consult the MRI Technologist or Radiologist if you have any question or concerns BEFORE you enter the MRI exam room.

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