SALEM TOWNSHIP HOSPITAL

SCREENING FORM: MRI ELIGIBILITY AND MEDICATION

Date:	Patient Name:	Date of Birth:

Type of Exam:

Patient to list home medications:

Patient to list major operation (date of surgery):

☐ No	☐ Yes	Pregnancy / Nursing / IUD / Pessary
☐ No	☐ Yes	Allergy to food, drugs, or other (be as specific as possible): *If yes, did you require treatment:* ☐ No ☐ Yes
☐ No	☐ Yes	Asthma
☐ No	☐ Yes	History of cancer
☐ No	☐ Yes	Heart disease
☐ No	☐ Yes	History of hypertension requiring medical therapy
☐ No	☐ Yes	Seizures
☐ No	☐ Yes	Diabetes
☐ No	☐ Yes	Renal/Kidney disease: ☐ Kidney failure ☐ Known cancer involving kidney(s) ☐ Kidney transplant ☐ Solitary kidney (one kidney) ☐ Other kidney disease/dysfunction/surgery ☐ Dialysis. Type: ☐ Peritoneal ☐ Hemodialysis; date initiated:
☐ No	☐ Yes	Medication patch (Nicotine, Nitroglycerine, etc.)
☐ No	☐ Yes	Insulin or any other drug infusion pump
☐ No	☐ Yes	Aneurysm clips (brain)
☐ No	☐ Yes	Aneurysm clips or any gastrointestinal clips (abdomen)
☐ No	☐ Yes	Intravascular coil, filter or stent
☐ No	☐ Yes	Brain surgery
☐ No	☐ Yes	Vascular surgery
☐ No	☐ Yes	Previous spinal surgery
☐ No	☐ Yes	Ear surgery
☐ No	☐ Yes	Eye surgery or Eye prosthesis
☐ No	☐ Yes	Heart surgery or prosthetic heart valve
☐ No	☐ Yes	Cardiac Pacemaker, neurostimulator (Tens unit)
☐ No	☐ Yes	Implanted heart defibrillator or ICD
☐ No	☐ Yes	Swan Ganz
☐ No	☐ Yes	Pacing leads
☐ No	☐ Yes	Tissue expander (i.e., breast)
☐ No	☐ Yes	Joint or limb replacement
☐ No	☐ Yes	Metal rods, pins, screws or other orthopedic devices
☐ No	☐ Yes	Any type of prosthesis (penile, limb, etc.)
☐ No	☐ Yes	Known metal or possible metal in head, eyes or body (piercing)
☐ No	☐ Yes	Has the patient ever been a metal worker, welder or grinder
☐ No	☐ Yes	War injuries or gunshot wounds
☐ No	☐ Yes	Any surgical staples
☐ No	☐ Yes	Hearing aid (must be removed before MRI)
☐ No	☐ Yes	Dentures
☐ No	☐ Yes	Tattoo or permanent makeup

Review by radiology technologist

Radiology Technologist Signature	Date	Time

SALEM TOWNSHIP HOSPITAL

CONSENT TO PERFORM MAGNETIC RESONANCE SCAN

Your physician has requested that we perform a Magnetic Resonance Scan to provide diagnostic information which he/she believes is important and will aid in the proper management of your case. Magnetic Resonance Imaging is a relatively new technique which involves the use of a magnetic field and radiofrequency signals to provide detailed pictures of internal structures of your body. While there are no known harmful effects of the magnetism or radiofrequency stimulation, certain precautions must be taken. If you are aware of any of the following conditions, you must advise the technologists and physicians conducting your examination.

- Currently Magnetic Resonance Scans are not performed during pregnancy expect for specific indications. If you are female and suspect that you may be pregnant, this should be reported to the technologists and physicians conducting your study.

- The high magnetic field and the radiofrequency stimulation may disrupt proper operation of certain medical electronic devices such as cardiac pacemakers and hearing aids.

- Surgically implanted metallic devices may be attracted to the magnet. All such devices should be reported to your attendants. Of most importance are any clips placed in the brain, especially those placed on aneurysms (dilated blood vessels) within the brain. Also important are implants in the ear.

- Pieces of metal accidently introduced into the body may also be attracted toward the magnet and can result in damage. Of special importance are any metallic foreign objects in or around the eye.

Your physician will be happy to answer any specific questions you may have about the procedure and the remote possibility of any complication relative to the precautions listed above.

I have read and understood the above information and agree to proceed with the diagnostic study. I have reported the presence of any of the above conditions to the technologists and physicians conducting my study.

Signature of Patient Date Time of Signature

If patient is a minor or mentally incompetent, signature of Power of Attorney for Healthcare, Parent or Guardian, or closest relative is required.

Relationship to Patient

Witness to Signature(s) Date Time of Signature