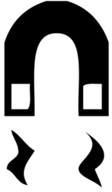
Culpeper Regional Hospital

Care | Competence | Compassion | Courtesy

MRI QUESTIONNAIRE / CONSENT FORM



The MRI system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR scan room – if they have had certain metallic, electronic magnetic or mechanical implants, devices or objects. Therefore, **ALL** individuals are required to fill out this form BEFORE entering the MR environment or MR scan room. **Be advised, the MR system is ALWAYS ON!**

Name________________________________ Age_____________ DOB______________________

Referring Physician_________________________ Medical Record#_________________________

Exam Requested____

If female, are you pregnant? NO___________ YES____________ NOT SURE_______________

Weight___________ Height______________

Medical Review

Yes	No		Yes	No	
___	___	Cardiac Pace Maker/Defibrillator	___	___	Tens Unit/other electrical implant
___	___	War Injury or Gun Shot	___	___	Dentures, Retainers, other dental implants?
___	___	Aneurysm Clips	___	___	Metal rod, pin or screw
___	___	Prior Brain Surgery	___	___	Joint replacement/other orthopedic prosthesis
___	___	Middle Ear Surgery	___	___	Cancer or Tumor
___	___	Prior Vascular Surgery	___	___	Radiation Therapy or Chemotherapy, including radiation seeds or implants
___	___	Tattoos / Permanent Eyeliner			
___	___	IUD, diaphragm, or pessary	___	___	Renal or Kidney Disease
___	___	Medicinal Patches	___	___	Hearing Aid

Technologist Review to any "Yes" answers: (initial) ____________

Action taken: ____

____

Are you claustrophobic (have a fear of enclosed spaces such as elevators)?	**Yes**	**No**
Are you taking any medication for claustrophobia or anxiety?	Yes	No

Is there any chance that you could have metallic objects in your eyes, head, or body?	**Yes**	**No**
Have you done metal work or welding as a profession or hobby?	Yes	No

List any previous surgeries relating to your exam today: ____________________________________

____

What are your symptoms?____

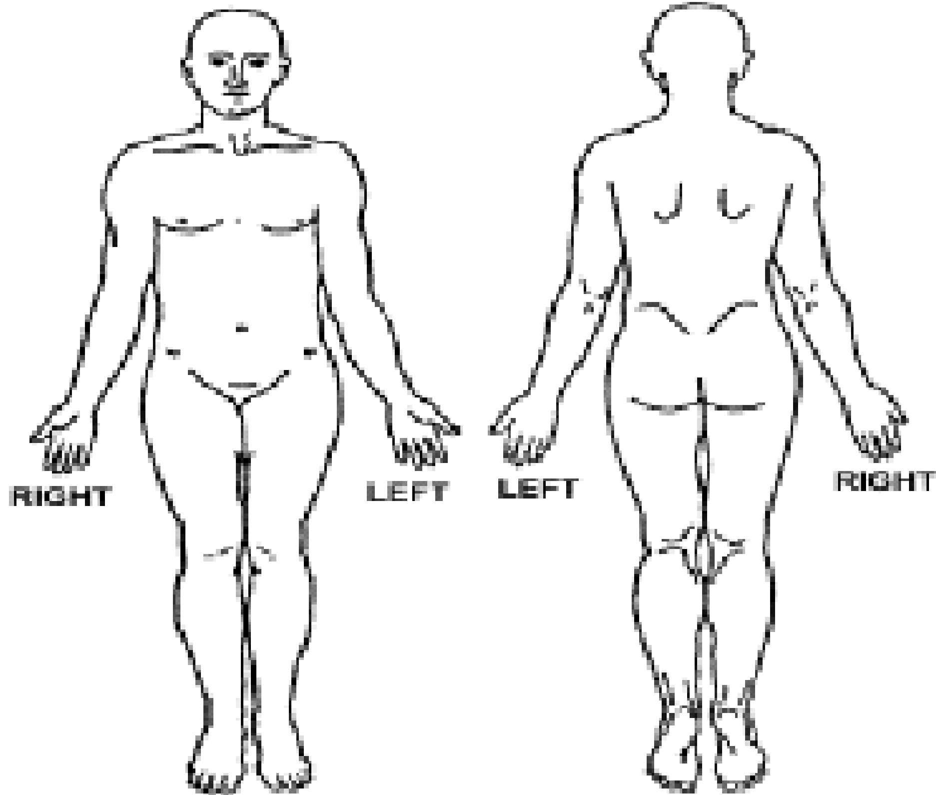
____

Allergies: _____________________________ Type of reaction: _________________________________

Have you had any previous exams done here? ____________Elsewhere? ________________________

What other tests have been done for your symptoms?____

**REMOVE ALL FERROMAGNETIC OBJECTS
INCLUDING WATCHES, JEWELRY, CREDIT CARDS, KEYS.**



Please draw a line or arrow to the areas that you feel pain in, including if/where the pain extends to. Briefly describe the nature of the pain, such as sharp, dull, shooting, pulsing, etc. Rate your pain from 1-10, 1 = a little & 10 = worst pain.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form, and I have had the opportunity to ask questions regarding the information on this form.

Patient (Legal guardian) signature: ________________________________ ***Date:*** ______________

Technologist signature (witness): ____

Adopted 05/96, revised 12/2010