Beth Israel Deaconess Medical Center
Boston, MA 02215

PATIENT'S NAME _____

MED. REC. # _____

DOB

MRI INPATIENT SCREENING QUESTIONNAIRE

Today's Date: _____/_____/_____

Patient's Name: _____ **Weight:** _____ **Height:** _____

An MRI involves the use of a very strong magnet. For your safety, the presence of certain metallic objects must be determined ***before*** you enter the exam room. Please place a check in the appropriate column for each item below and provide as much information as possible about any implanted devices.

MR2063

	Yes	No
1. Pacemaker / Pacer wires / Implantable defibrillator Date: ____/____/____ Make / Model #:_____		
2. Intracranial or brain aneurysm clip (brain surgery) Date: ____/____/____ Make / Model #:_____		
3. Have you had an MRI before? ***If yes***, did you receive a contrast injection?		
4. Have you had an MRI in the past 7 days? ***If yes***, did you receive a contrast injection?		
5. Metallic heart valve or any metallic stents Date: ____/____/____ Make / Model #:_____		
6. Bio or neurostimulator, electronic device or implant Date:____/____/____ Make / Model #:_____		
7. Tattoo(s), Tattooed eyeliner Location: _____		
8. Body piercing ***If yes***, location(s):_____		
9. Metal injury to the eye requiring medical attention ***If yes***, date of injury:____/____/____		
10. Shrapnel (metal in body) Location:_____		
11. Ear surgery or prosthesis Date:____/____/____ Type or Model:_____		
12. Eye surgery or prosthesis Date:____/____/____ Type or Model:_____		
13. Limb or joint replacement or pinning Location:_____		
14. Tissue expander (*e.g.* breast implant)		
15. Are you currently undergoing an endoscopy study that uses a small pill camera?		

	Yes	No
16. Are you wearing a patch that delivers medication?		
17. Do you have a history of difficult IV starts?		
18. Do you have an implanted port or indwelling catheter? Type:_____		
19. Implanted pump (insulin, pain med, chemotherapy) Type: _____ Location:_____		
20. Are you on dialysis? ***If yes***, how often:_____		
21. Please **list** all surgeries: _____ _____ _____ _____ _____		
22. Please ***check*** if you have any of the following medical conditions: ☐ Asthma / Hay fever ☐ Heart Disease ☐ Multiple Myeloma ☐ Thyroid Disease ☐ Pheochromocytoma ☐ Sickle Cell Disease		
FEMALES ONLY:	**Yes**	**No**
23. Is there any possibility of pregnancy?		
24. Intrauterine Device (IUD) or Diaphragm Type or Model: _____		
25. Pessary (in pelvis)		
MALES ONLY:	**Yes**	**No**
26. Do you have a penile implant? ***If yes***, make and model: _____		

MRI Staff will speak to you about the need for removing the following items:

Removable dental work | Eyeglasses | Wallet / keys | Watch / Jewelry | Credit and ATM (Automated Machine) cards | Hearing aids | Wigs / hairpieces or bobby pins

X_____ or **X** _____ and _____ ____/____/____
Patient's Signature | Person authorized to sign for patient | Relationship to patient | Date

X_____ _____ ____/____/____ __ __ __ __
Nurse or Technologist Signature | Print Name | Date | Time (24 hour)

HOSPITAL STAFF ONLY - Form re-certification for return to MRI during same admission:

☐ No changes since original form completion ☐ Amendments to original form as follows:

_____

_____

X_____M.D. / N.P. / P.A. _____ M.D. / N.P. / P.A. ____/____/____ __ __ __ __
Signature | Print Name | Date | Time (24 hour)

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Patient Identification

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Roughly 25% of attempts at MRI for patients in the hospital result in a non-diagnostic study. To help us serve the entire patient population safely and effectively, please respond to the questions below.

PATIENT ASSESSMENT (TO BE COMPLETED BY M.D., N.P., P.A. or R.N.)	**Yes**	**No**
27. Does this patient have an epidural or Swan-Ganz catheter?		
28. Is this patient mechanically ventilated?		
29. Does the patient have a Bivona® tracheotomy tube?		
30. Does this patient require telemetry during MRI?		
31. Does this patient have intravenous medication that must run during the MRI?		
32. Does this patient have a working peripheral IV, which can be dedicated for contrast administration?		
33. Does this patient consistently follow commands?		
34. Can this patient lay flat (supine) and motionless for at least 30 minutes? *Note: some MRI studies require the patient to be flat and motionless for 2-3 hours		
35. Does this patient require pre-medication for pain or nausea?		
36. Does this patient require sedation for claustrophobia, anxiety, or confusion? ***If Yes***, please indicate which level of sedation you think is most appropriate: _____ **1:** Light sedation for anxiolysis (preferred treatment is Xanax® 0.5 - 2.0 mg sublingual 45-60 minutes prior) **2:** Monitored anesthesia care **3:** General anesthesia		
37. Is this patient NPO? ***If Yes***, NPO as of: _____/_____/_____ **at** ___ ___ ___ ___ Date Time (24 hour) ***If No***, last food and drink were: _____/_____/_____ **at** ___ ___ ___ ___ Date Time (24 hour)		

Comments:

X_____ _____ _____ _____/_____/_____ ___ ___ ___ ___

M.D./ N.P. / P.A. / R.N. Signature | Print Name | Pager # | Date | Time (24 hour)

IV Site: _____ **IV Tech:** _____

Gauge: _____ **Scan Tech:** _____