Date:___/___/___ **College Park MRI Pre-Screening** 913-956-4200 fax 913-428-1445

Name: _____ Pt ID: _____ Weight _____ **(Weight Limit of table 450#)**
Last First Middle Initial

Date of Birth___/___/___ **Age_____** ☐Male ☐Female ****Exam** _____ Physician _____

Symptoms_____ Special needs (wheelchair, oxygen, extra time)_____

Previous imaging on this body part, where, when?_____

		Please describe for any questions with a YES response
Do you have any drug allergies	☐**YES** ☐ **NO**	
Are you a diabetic	☐**YES** ☐ **NO**	**If yes, do you take insulin?**
Are you on Metformin/Metformin containing drug combo	☐**YES** ☐ **NO**	
Do you have a history of renal disease	☐**YES** ☐ **NO**	
Do you currently take medications for high blood pressure	☐**YES** ☐ **NO**	
Do you have a history of kidney transplant	☐**YES** ☐ **NO**	
Do you have a single kidney	☐**YES** ☐ **NO**	
Do you have a history of kidney/renal cancer	☐**YES** ☐ **NO**	
Have you ever had renal surgery	☐**YES** ☐ **NO**	
Are you on dialysis	☐**YES** ☐ **NO**	
Do you have a history of cancer	☐**YES** ☐ **NO**	**If yes, type of cancer and year diagnosed**
Have you been hospitalized or treated by a physician within the past 30 days for dehydration, febrile illness, sepsis, heart failure, abdominal surgery or for liver disease?	☐**YES** ☐ **NO**	
Do you have Hemolytic/Sickle Cell Anemia	☐**YES** ☐ **NO**	
Are you or could you be pregnant	☐**YES** ☐ **NO**	**Are you currently breast feeding** ☐**YES** ☐ **NO**
Date of Last Menstrual Cycle ***Check all applicable:***		☐ hysterectomy ☐ tubal ligation ☐ Mirena/Skyla IUD ☐ ablation ☐ Depo provera shots ☐ post menopausal for greater than 1 year

Please mark YES or NO to all questions

YES / NO Coronary stent- ***Year Implanted____ Type_____*** ****Send copy of implant card with assessment****

YES / NO Heart Surgery
YES / NO Pacemaker, pacemaker wires, defibrillator
YES / NO Heart valve, filter, coils
YES / NO Brain surgery/Brain clips
YES / NO Shunt
YES / NO Aneurysm Surgery
YES / NO Orthopedic hardware (plates, pins, screws)
YES / NO Artificial limb or joint replacement
YES / NO Staples, wires, mesh
YES / NO Pain/Infusion/Insulin pump
YES / NO Implanted Electric stimulator
YES / NO Magnetic/Mechanical/Electrical implants
YES / NO Endoscopy clip implanted-***Date:_____***
YES / NO Ear surgery: ***Type_____***
YES / NO Eye surgery***: Type_____***

YES / NO Claustrophobic
YES / NO Tattoos/Permanent make-up
YES / NO Bullets, BB's, shrapnel
YES / NO Metal shavings in eye****
****If yes, did a doctor remove all the metal YES/NO****

<u>Items below need to be removed prior to MRI</u>

YES / NO Dentures or partial plates
YES / NO Adhesive medication patch
YES / NO Hearing Aids
YES / NO **All** Piercings and jewelry
YES / NO Wig, Hairpins, or Barrettes
YES / NO Magnetic eyelashes
YES / NO Guns, Knives, Concealed weapons
Other _____
_____

YES / NO Is the exam a Brain?	**YES / NO Is the exam a Spine?**
Brains are always W&W/O for the following reasons:	**Spines are always W&W/O for the following reasons:**
YES / NO Multiple Sclerosis (M.S.)	**YES / NO** Previous surgery on the spine being imaged
YES / NO Demyelinating Disease	**YES / NO** Multiple Sclerosis (M.S.)
YES / NO History of Cancer	**YES / NO** Demyelinating Disease
YES / NO History of Brain Surgery	**YES / NO** History of Cancer
YES / NO IAC's	**YES / NO** Myelopathy
YES / NO Orbits	**YES / NO** Osteomyelitis
YES / NO Pituitary	**YES / NO** Diskitis
	YES / NO Infection