Cooperative Magnetic Imaging Safety Screening Questionnaire

01/16 kt

Patient Name____ D.O.B.____________________

(circle one)

1. Have you ever had surgery?.. YES NO
   If yes, please list types and dates:____
   ____
2. Have you had **any** surgical procedures in the last 6 weeks?.. YES NO
   If yes, please list types & dates:____
3. Have you ever worked with metal (grinding, fabrication, machine shop)……………………… YES NO
4. Have you ever had any metallic objects in your eyes (slivers, foreign body, etc.) ……………. YES NO
   If yes, please describe____
5. Do you have any Food or Medication allergies?.. YES NO
   If yes, please list ____
6. Are you currently undergoing Dialysis treatment?... YES NO
7. Are you on any Blood or Body Fluid Precautions or Infection Control Precautions?
   (i.e. TB, Hepatitis, Shingles, MRSA, VRE, HIV, etc.)………..……………………………..... YES NO
8. Are you Pregnant or suspect that you might be?.. YES NO
   Date of your Last Menstrual Period ____
9. Are you currently Breastfeeding?.. YES NO
10. Do you have any body piercings or body jewelry? (please list)________________________ YES NO
11. Have you ever had a reaction to contrast medium used for MRI or CT?.............................. YES NO
12. Do you have or have you ever had a detached retina? …………………………………… YES NO
13. Do you have a history of High Blood Pressure, Diabetes, Kidney or Liver Disease?............ YES NO
14. Have you had or are you scheduled to have a liver transplant?.. YES NO
15. Do you have a problem with the ability to stay still or claustrophobia?.................................... YES NO
16. Have you traveled outside the U.S. in the last 21 days? If yes, where?....................... YES NO

Do you have any of the following? **(circle yes or no)**

Aneurysm Clips or Coils	YES	NO	Any type of implant (eye, penile, etc.)	YES	NO
Cardiac Pacemaker or Defibrillator	YES	NO	Any type of prosthesis (eye, hip, etc.)	YES	NO
Loop Recorder	YES	NO	Any Artificial Limbs or Joint Replacements	YES	NO
Heart Valve Prosthesis	YES	NO	Surgical Staples, Clips or Sutures	YES	NO
Internal or Residual Pacer Wires	YES	NO	Bone/Joint Pins, Plates, Nails or Screws	YES	NO
ANY Stents or Filters	YES	NO	Insulin or Infusion Pump	YES	NO
ANY Shunt (spinal, intraventricular, etc)	YES	NO	Bone Growth or Fusion Stimulator	YES	NO
Internal Electrodes or Wires	YES	NO	Neurostimulator	YES	NO
Vascular access port and/or catheter	YES	NO	Dentures, Braces, or Removable Dental items	YES	NO
Ear implant or Hearing Aid	YES	NO	Medication/Skin Patch (nitro, nicoderm, ortho, etc.)	YES	NO
Radiation Seeds or Implants	YES	NO	IUD, Pessary or Diaphragm	YES	NO
History of Seizures	YES	NO	Asthma or Respiratory Disease (circle which)	YES	NO
Shrapnel, Bullets Fragments or Metal Your Body	YES	NO	Tattoos or Tattooed Makeup	YES	NO
			Other (explain):	YES	NO

*******<u>ANY</u> "YES" answers need clarification with CMI Prior to Transfer of Services*******

* You or anyone accompanying you into the scan room will be asked to remove all metallic items such as hair pins, keys, batteries, jewelry, watches, safety pins, paperclips, money clips, credit cards, hearing aids, dentures, coins, eyeglasses, pens, belts, clothing with metal, pocket knife, pagers, cell phones, etc.

By signing below, I grant consent for the study and I attest that I understand the contents of this form; that the above information is correct to the best of my knowledge and I have had an opportunity to ask questions regarding the information on this form.

Current
Weight __________ ____ ____________

(Signature of person completing form) (Date)

Form completed by: Patient Relative or Patient Representative____________________________________

(check one) (Print name and relationship to patient)

To be completed by CMI:
Checked in by: (front office)______________________________ Reviewed by (tech)______________________________
(Signature and date) (Signature and date)