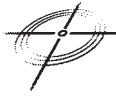


# HILLSBORO IMAGING

1909 Acklen Avenue  
Nashville, TN 37212  
PHONE #: 777-9729  
www.hillsboroimaging.com



# COOL SPRINGS IMAGING

2009 Mallory Lane, Suite 150  
Franklin, TN 37067  
PHONE #: 771-8668  
www.coolspringsimaging.com

## ***MRI PROCEDURE SCREENING FORM***

Welcome to Vanderbilt Imaging Services. Your scan will usually require from 15 minutes to 1 hour depending on the type of scan your physician has ordered. Please do not hesitate to ask our staff any questions you may have.

Name \_\_\_\_\_ Weight \_\_\_\_\_

Medical reason for your scan today (in your own words). \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**YES NO**

Have you ever had a surgical procedure or operation of any kind?   If yes, please list all prior surgeries and approximate dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been injured by any metallic foreign body?   If yes, please describe:  
*(e.g., bullet, BB, pellets, shrapnel, etc.)*

\_\_\_\_\_  
\_\_\_\_\_

Have you ever had an injury to the face or eye involving a metallic object?   If yes, please describe:  
*(e.g., metallic slivers, shavings, foreign body, etc.)*

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been a machinist, welder, or metal worker?

Are you pregnant or do you suspect that you are pregnant?

Are you breast feeding?

Have you had a previous MR or CT scan?   If yes, Type of scan: \_\_\_\_\_

Performed at: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PLEASE SEE OTHER SIDE FOR MORE INFORMATION

**THE FOLLOWING ITEMS MAY BE HAZARDOUS OR MAY INTERFERE WITH THE MRI EXAMINATION BY PRODUCING AN ARTIFACT.**

*Please indicate if you have any of the following:*

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Brain Aneurysm clip(s)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart valve prosthesis  |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of internal electrode(s), including:<br>Cardiac defibrillator or Pacemaker<br>Pacing wires<br>Cochlear implant<br>Nerve or Bone Stimulator<br>Other: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of electronic, mechanical, or magnetic implant<br>Type: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Implanted catheter, tube, shunt, or vascular access port  |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of blood vessel coil, filter, wire or stent.<br>Type: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Implanted drug infusion device, including insulin pump  |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial limb or joint  |
| <input type="checkbox"/> | <input type="checkbox"/> | Any implanted orthopedic hardware<br>(i.e., pins, rods, screws, nails, clips, plates, wire, etc.)<br>Type: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Halo vest or metallic cervical fixation device  |

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Surgical clips, staples, wire mesh or sutures             |
| <input type="checkbox"/> | <input type="checkbox"/> | Orbital / eye prosthesis                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Penile prosthesis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Any other implanted item Type: _____                      |
| <input type="checkbox"/> | <input type="checkbox"/> | IUD or Diaphragm  |
| <input type="checkbox"/> | <input type="checkbox"/> | False teeth, retainers or magnetic braces                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Tattooed eyeliner   |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermal patches (i.e. smoking, hormonal, medication, etc.) |

**Do you have any metal inside your body?**

YES       NO

**If yes, where?** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**\*If you have answered YES to any of the questions, please notify the receptionist so she may notify the MRI Technologist.**

The following items may become damaged or cause injury to others in a strong magnetic field.  
**THEY MUST NOT BE TAKEN INTO THE MR SCAN ROOM, UNLESS APPROVED BY AN MR TECHNOLOGIST.**  
 Place an "x" by any item you have with you on the list below.

___ Hearing aid	___ Keys
___ Glasses	___ Coins
___ Watch	___ Pocketknife
___ Safety pins	___ Credit or bank cards
___ Hairpins / barrettes	___ Artificial limb / prosthesis
___ Wigs / Hair pieces	___ Dentures / Partial plates retainers
___ Jewelry	___ Belt buckle
___ Wallet / Money clip	___ Bra / girdle / sanitary belt
___ Purse / Pocketbook	___ Metal zippers / buttons
___ Pens / Pencils	

**INFORMATION CONCERNING GADOLINIUM CONTRAST MATERIAL**

As part of your examination, the MR radiologist may deem it advisable to give you an I.V. injection of a contrast agent containing gadolinium. This injection may help the physician more accurately diagnose your condition. Although gadolinium contrast agents have been used safely in millions of cases, minor reactions (principally headache or nausea) occur in about 2% of patients, whereas serious or life-threatening reactions have been reported on about one in 400,000 patients.

	YES	NO
Have you ever had a previous allergic reaction to MR contrast dye material?	<input type="checkbox"/>	<input type="checkbox"/>

Do you have a history of seizure, asthma, allergic or chronic respiratory disease, including emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
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*I attest that the information I provided 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.*

Signature (Patient or Guardian): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

MRI Technologist: \_\_\_\_\_