ATLANTIC
RADIOLOGY
Pooler Imaging Center

Magnetic Resonance Imaging Screening

Patient: ________________________________

DOB:_________ Age:_________ Sex:______

Weight:__________ Height:________________

Referring Physician: _________________________

The reason you are here today. Please explain your medical problems in detail. (What is your problem? Where is the problem? etc.)

____

Is your problem related to an injury? ☐ Yes ☐ No

How were you injured? ☐ Work ☐ Motor Vehicle Accident ☐ Other

Do you have or have you ever had any of the following?

- Pacemaker, wires, defibrillator/neurostimulator ☐ Yes ☐ No
- Brain aneurysm clip/brain surgery ☐ Yes ☐ No
- Eye implant/eye surgery/eye injury ☐ Yes ☐ No
- Gunshot wounds/bullets, BBs, or pellets ☐ Yes ☐ No
- Magnetic implant anywhere ☐ Yes ☐ No
- Coil, filter, or wire in blood vessel ☐ Yes ☐ No
- Tattoo/permanent makeup ☐ Yes ☐ No
- Artificial heart valve ☐ Yes ☐ No
- Shunt/stents/intravascular coils ☐ Yes ☐ No
- Surgical clips, staples, wires, mesh, or stitches ☐ Yes ☐ No
- Ortho devices (plates, screws, pins, rods, wires) ☐ Yes ☐ No
- Body piercings/pins in your hair or clothes ☐ Yes ☐ No
- Ear implant/cochlear implants/hearing aids ☐ Yes ☐ No
- Electrical stimulator for nerves or bones ☐ Yes ☐ No
- Metal shrapnel or fragments ☐ Yes ☐ No

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DOB:__________ Age:__________ Sex:_______

Weight:___________ Height:__________________

- Insulin or infusion pump ☐ Yes ☐ No
- Artificial limb or joint ☐ Yes ☐ No
- Implanted catheter or tube ☐ Yes ☐ No
- Penile prosthesis ☐ Yes ☐ No
- False teeth, retainers, dentures, partials ☐ Yes ☐ No
- Diaphragm or intrauterine devices ☐ Yes ☐ No
- Claustrophobia ☐ Yes ☐ No
- History of cancer? ☐ Yes ☐ No

Contrast Section:

Patient Signature: ________________________________ **Date:**_____________________

Technologist Signature: ________________ **Date:**________________