RWJBarnabas HEALTH

DOWNTIME MRI Screening Questionnaire

Patient Name: ____
(First, Middle, Last)

Account #: _____________________ **MRN**: _________________________

DOB: ____/____/____ **Age**: _________ **Gender**: ________ **Weight**: ________ **Height**: _______

☐ **Outpatient** ☐ **ER Patient** ☐ **Inpatient – Unit**: ________ **Room**: ________ **Bed**: ________

MRI Procedure: ____

Is the patient disoriented or will need help answering questions about their history during their appointment? ▪ If Yes, please be aware that the patient must be accompanied at the time of this appointment. Provide the name, contact number, and relationship of the person accompanying this patient accompanying the patient:	Yes / No
Has the patient had a reaction to contrast medium or dye used for an MRI examination? • If Yes, what was the reaction? (Circle one) Hives/Rash Trouble Breathing/Anaphylaxis Other ○ If Other, please explain:	Yes / No
Has the patient had a reaction to contrast medium or dye used for a CT or X-Ray examination? • If Yes, what was the reaction? (Circle one) Hives/Rash Trouble Breathing/Anaphylaxis Other ○ If Other, please explain:	Yes / No
Has the patient had a SEVERE allergic reaction to ANY medications? A severe allergy includes trouble breathing, anaphylaxis, life threatening reaction, or any reaction that required medical intervention. ▪ List each medication and the reaction to each medication (reaction MUST be included):	Yes / No
Patient's height in feet & inches?	_____ (Feet) _____ (Inches)
Has the patient ever experienced any problems related to a previous MRI examination or MRI procedure? ▪ If Yes, describe the problems experienced:	Yes / No
Has the patient ever had an eye injury or a metal fragment in their eye? • Describe the eye injury:	Yes / No
Has the patient had surgery on their eyes, or a metal fragment removed from their eyes? • Describe the eye surgery/procedure:	Yes / No
Has the patient had any Bullets, Shrapnel, BB, Buckshot or any metallic fragments anywhere in their body? • Describe the object and body site:	Yes / No
Is the patient wearing a LifeVest?	Yes / No

Female Patients

Is there any possibility of pregnancy? ▪ If Yes, what is your expected delivery date?	Yes / No ____/____/____
What is the patient's Menstrual Status? ☐ Ablation ☐ Born without uterus ☐ Chemotherapy/radiation ☐ Injection ☐ Implant ☐ Having periods ☐ Hysterectomy ☐ Recent Pregnancy ☐ Oopherectomy ☐ Perimenopausal ☐ Postmenopausal ☐ Premenarcheal ☐ Premenopausal	
When was the patient's last menstrual period? Indicate if the date is exact or approximate. If unknown, select "Unknown".	____/____/____ Exact/Approximate/Unknown
Is the patient currently breast feeding?	Yes / No
Does the patient have an IUD?	Yes / No
Does the patient have a Diaphragm, Pessary or Menstrual Cup?	Yes / No

Do you have any of the following Implants?

Yes / No	Pacemaker, Defibrillator, AICD or Abandoned Pacemaker Leads?	Make/Model, Manufacturer, Serial # and Date Placed: Cardiologist's name and phone number:
Yes / No	Loop Recorder	Make/Model, Manufacturer, Serial # and Date Placed:
Yes / No	Swan-Ganz or Thermodilution Catheter	Make/Model, Manufacturer, and Date Placed:
Yes / No	Tissue Expander (Breast, etc)	Make/Model, Manufacturer, and Date Placed:
Yes / No	Joint Replacement	Make/Model, Manufacturer, Date Placed and Body Site:
Yes / No	Harrington Rods (Spine)	Date Placed:
Yes / No	Ear Implant/Cochlear Implant	Make/Model, Manufacturer, Serial #, Date Placed and Which Ear:
Yes / No	IVC Filter/Greenfield Filter/SVC Filter	Make/Model, Manufacturer, Date Placed and Body Site:

DOWNTIME MRI Screening Questionnaire

RWJBarnabas HEALTH

Patient Name: ____

(First, Middle, Last)

Account #: _______________________ **MRN**: ___________________________

DOB: ____/____/____ **Age**: _________ **Gender**: ________ **Weight**: ________ **Height**: _______

☐ **Outpatient** ☐ **ER Patient** ☐ **Inpatient** – **Unit**: ________ **Room**: ________ **Bed**: ________

Do you have any of the following Implants (continued)?

Yes / No	Neurostimulator/Nerve Stimulator/Spinal Cord Stimulator	Make/Model, Manufacturer, Serial #, Date Placed and Body Site: Patient to bring their remote or controller with them to their appointment.
Yes / No	Bone Growth/Bone Fusion Stimulator	Make/Model, Manufacturer, Serial #, Date Placed and Body Site:
Yes / No	Brain Aneurysm Coil(s)	Make/Model, Manufacturer and Date Placed:
Yes / No	Brain Aneurysm Clip(s)	Make/Model, Manufacturer and Date Placed:
Yes / No	Carotid Artery or Other Vascular Clamp	Make/Model, Manufacturer, Serial #, Date Placed and Body Site:
Yes / No	Abdominal Graft/Aneurysm Clip	Make/Model, Manufacturer, Date Placed and Body Site:
Yes / No	Artificial Heart Valve	Make/Model, Manufacturer, Serial # and Date Placed:
Yes / No	Cardiac Stent	Make/Model, Manufacturer, Serial # and Date Placed:
Yes / No	Atrial Appendage Closure Device/WATCHMAN	Make/Model, Manufacturer, Serial # and Date Placed:
Yes / No	Stent in any vessel, duct, etc. other than the heart	Make/Model, Manufacturer, Serial #, Date Placed and Body Site:
Yes / No	Tracheostomy Tube	Make/Model, Manufacturer, and Date Placed:
Yes / No	PEG Tube	Make/Model, Manufacturer, Date Placed and Body Site:
Yes / No	LINX or Other Reflux Management System Device	Make/Model and Date Placed:
Yes / No	Brain/Spinal Shunt	Make/Model, Manufacturer, Serial #, Date Placed and Body Site: Neurologist to see patient within 24 hours after the MRI
Yes / No	Magnetically Activated Implant or Device	Make/Model, Manufacturer, Serial #, Date Placed and Body Site:
Yes / No	Penile Implant	Make/Model, Manufacturer, Serial # and Date Placed:
Yes / No	Eye Prosthesis	Make/Model, Manufacturer, Serial #, Date Placed and Which Eye:
Yes / No	Eyelid Implant	Make/Model, Manufacturer, Serial #, Date Placed and Which Eye:
Yes / No	Wire Mesh Implant	Make/Model, Manufacturer, Date Placed and Body Site:
Yes / No	Artificial Limb	Make/Model, Manufacturer, Serial #, Date Placed and Body Site:
Yes / No	CPAP Implant (such as Inspire)	Make/Model, Manufacturer, Serial # and Date Placed:
Yes / No	Infusion Pump (Insulin or other medication)	Make/Model, Manufacturer, Serial #, Date Placed, Body Site and Medication Being Delivered:
Yes / No	Dialysis/Intravascular Shunt	Date Placed and Body Site:
Yes / No	Glucometer Implant (Continuous Glucose Monitoring)?	Make/Model, Manufacturer, Serial #, Date Placed and Body Site:
Yes / No	Vascular Access Port and/or Catheter	Make/Model, Manufacturer, Date Placed and Body Site:
Yes / No	Aquapheresis Midline Catheter	Make/Model, Manufacturer, Serial #, Date Placed and Body Site:
Yes / No	Radiation Seeds or Implants	Date Placed and Body Site:
Yes / No	Metal Rods or Plates in Bones	List each Body Site of metal rods or plates:
Yes / No	Any surgical screws, staples, pins, clips, or metallic sutures	Describe your surgical screws, staples, etc:
Yes / No	Any Other Surgical Implants	Describe the Other Surgical Implant:
Yes / No	Any Other Electronic Implant or Device?	Make/Model, Manufacturer, Serial #, Date Placed and Body Site:

DOWNTIME MRI Screening Questionnaire

RWJBarnabas HEALTH

Patient Name: ____
(First, Middle, Last)

Account #: _______________________ **MRN**: ___________________________

DOB: ____/____/____ **Age**: _________ **Gender**: ________ **Weight**: ________ **Height**: _______

☐ **Outpatient** ☐ **ER Patient** ☐ **Inpatient – Unit**: ________ **Room**: ________ **Bed**: ________

Surgical /Procedural History

Yes / No	Small Bowel Endoscopy Capsule (Pillcam, Endoscopic Capsule)?	Date capsule swallowed __/__/____
Yes / No	Colonoscopy or Upper Endoscopy in past 3 months?	Was a clip placed during the Colonoscopy/Endoscopy? Yes / No
Yes / No	Any Other Surgeries?	List the date and type of each surgery:

Patient History

Yes / No	Tattoos? If yes, what country?	Yes / No	Do you have any Removable Dentures or Partial Plates?
Yes / No	Permanent Eyeliner? If yes, what country?	Yes / No	Are you wearing a Medication Patch?
Yes / No	Permanent Makeup? If yes, what country?	Yes / No	Is the patient wearing a Nicotine Patch?
Yes / No	Does the patient have Hair Implants?	Yes / No	Does the patient have Electrodes (on body, head or brain)?
Yes / No	Is the patient claustrophobic?	Yes / No	Is the patient wearing Clothing with Metallic Fibers (Athletic Wear)?
Yes / No	Is the patient wearing an RFID or radiofrequency ID device?	Yes / No	Is the patient wearing a Halo Vest or Metal Cervical Fixation Device?
Yes / No	Does the patient have a Wound Vac with Silver Sponge?	Yes / No	Does the patient have any Body Piercings?
Yes / No	Does the patient have a Temperature Sensing Foley?	Yes / No	Does the patient have any Body Augmentation Implants?
Yes / No	Is the patient wearing hearing aids?	Yes / No	Does the patient have magnetic eyelashes?
Yes / No	Does the patient have a SENSIMED Trigger Fish Contact Lens?	Yes / No	Is the patient wearing a wig, hair extensions or hair piece?
Yes / No	Does the patient have any EKG or Holter Monitor Leads?		

*You will be required to remove all jewelry, including body piercings, and hearing aids before entering the room.

I agree the above information is correct. I have read and understand the entire content of this form and have had the opportunity to ask questions regarding the information on this form.

Patient:

____
(Print Name)

____________________________ __________ _______
(Signature) (Date) (Time)

Direct Family Member:

____
(Print Name)

____________________________ __________ _______
(Signature) (Date) (Time)

Translator:

____
(Language)

____________________________ __________ _______
(Print Translator Name) (Date) (Time)

RN/MD Completing Form (circle one**)**

____
(Print Name)

____________________________ __________ _______
(Signature) (Date) (Time)

MRI Staff Verification #1

____
(Print Name)

____________________________ __________ _______
(Signature) (Date) (Time)

MRI Staff Verification #2

____
(Print Name)

____________________________ __________ _______
(Signature) (Date) (Time)