AULTMAN ALLIANCE COMMUNITY HOSPITAL

Fax to AACH MRI Department 330-596-7779

Patient Name: _____ DOB: _____

Height: _____ Weight: _____ Exam and exam date: _____

Please indicate if you have any of the following at this time:

___ **Yes** ___ **No** Aneurysm surg/clip(s)
___ **Yes** ___ **No** Cardiac pacemaker
___ **Yes** ___ **No** Implanted cardioverter defibrillator (ICD)
___ **Yes** ___ **No** Electronic implant or device
___ **Yes** ___ **No** Magnetically-activated implant or device
___ **Yes** ___ **No** Neurostimulation system
___ **Yes** ___ **No** Spinal cord stimulator
___ **Yes** ___ **No** Internal electrodes or wires
___ **Yes** ___ **No** Bone growth/bone fusion stimulator
___ **Yes** ___ **No** Cochlear, otologic, or other ear implant
___ **Yes** ___ **No** Insulin or other infusion pump
___ **Yes** ___ **No** Implanted drug infusion device
___ **Yes** ___ **No** Any type of prosthesis (eye, penile, etc.)
___ **Yes** ___ **No** Open heart surg.
___ **Yes** ___ **No** Heart valve prosthesis
___ **Yes** ___ **No** Eyelid spring or wire
___ **Yes** ___ **No** Artificial or prosthetic limb
___ **Yes** ___ **No** Metallic stent, filter, or coil
___ **Yes** ___ **No** Shunt (spinal or intraventricular)
___ **Yes** ___ **No** Vascular access port and/or catheter
___ **Yes** ___ **No** Radiation seeds/ penile implants / urinary implants
___ **Yes** ___ **No** Swan-Ganz or thermodilution catheter
___ **Yes** ___ **No** Medication patch (Nicotine, Nitroglycerine)
___ **Yes** ___ **No** Any metallic fragment or foreign body / gunshot wounds
___ **Yes** ___ **No** Wire mesh implant
___ **Yes** ___ **No** Tissue expander (e.g., breast)
___ **Yes** ___ **No** Surgical staples, clips, or metallic sutures
___ **Yes** ___ **No** Joint replacement (hip, knee, etc.)
___ **Yes** ___ **No** Bone/joint pin, screw, nail, wire, plate, etc.
___ **Yes** ___ **No** IUD, diaphragm, or pessary
___ **Yes** ___ **No** Dentures, partial plates, braces
___ **Yes** ___ **No** Tattoo or permanent makeup / wig / hairpiece
___ **Yes** ___ **No** Body piercing jewelry
___ **Yes** ___ **No** Hearing aid
___ **Yes** ___ **No** Brain surg.
___ **Yes** ___ **No** Claustrophobia
___ **Yes** ___ **No** Recent endoscope / colonoscopy

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads. Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. I also give permission to Aultman Alliance Community Hospital MRI department to obtain records to determine safety for the exam and/or for comparison to my exam.

Signature of Person Completing Form: _____

Date _____/_____/_____ Form Completed By: ___ Patient ___ Relative ___ Nurse

Form Information Reviewed By: _____

____ MRI Tech**no**logist ____ Nurse ____ Radiologist

Other (relationship)_____

Secondary Form Review (if applicable): _____

____ MRI Tech**no**logist ____ Nurse ____ Radiologist

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, colonoscopy etc.) of any kind?

Please list all surgeries: _____

_____

_____

2. Have you had a prior diagnostic imaging study or examination on the body part being imaged today (MRI, CT, Ultrasound, X-ray, etc.)? ___No ___ Yes
If yes, please specify exam, facility and study date: _____

_____

3. Do you have a history of cancer? ___ No ___ Yes Type / where / year of diagnosis :
_____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ___ No ___ Yes

If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?
___ No ___ Yes
If yes, please describe: _____

6. Are you allergic to beestings? ___ No ___ Yes What is your reaction:_____

7. Are you allergic to any medication? ___ No ___ Yes
If yes, please list:_____

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ___ No ___ Yes
What is your reaction:_____

9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, kidney stones, kidney failure or seizures? ___ No ___ Yes
If yes, please describe: _____

For female patients:
10. Date of last menstrual period:_____/_____/_____ Post menopausal? ___ No ___ Yes

11. Are you pregnant or experiencing a late menstrual period? ___ No ___ Yes

12. Are you currently breastfeeding? ___ No ___ Yes