KONA COMMUNITY HOSPITAL

79-1019 HAUKAPILA STREET
KEALAKEKUA, HAWAII 96750
HAWAII HEALTH SYSTEMS
CORPORATION

MRI Procedure Screening Questionnaire

Date: _____/_____/_____ MRN: _____

Name: _____ Age: _____ Gender: M / F
Last name First name Middle initial

DOB: ____/____/_____ Height: _____ Weight: _____ Telephone #: _____
Reason for MRI and/or symptoms: _____
_____

1) Have you had any prior surgery or an operation: **Yes / No**. If yes, please indicate date and type of surgery/operation.

_____
_____
_____
_____

2) Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? **Yes / No.**
If yes, please list:

	Body Part	**Date**	**Facility**
MRI	_____	_____/_____/_____	_____
CAT Scan	_____	_____/_____/_____	_____
X-Ray	_____	_____/_____/_____	_____
Ultrasound	_____	_____/_____/_____	_____
Nuclear Medicine	_____	_____/_____/_____	_____
Other_____	_____	_____/_____/_____	_____

3) Have you experienced any problems related to a previous MRI examination or MR Procedure? **YES / NO**
4) Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? **YES / NO**. If yes, please explain: _____
5) Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? **YES / NO.** If so, please explain: _____
6) 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? **YES / NO**.
7) Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) transplant, high blood pressure(hypertension), liver(hepatic) disease, a history of diabetes, or seizures? **YES / NO**. If so, please describe:
_____

For Female Patients:
8) Date of last menstrual period: _____/_____/_____ Post-menopausal? **YES / NO**
9) Are you pregnant or experiencing a late menstrual period? **YES / NO**
10) Are you taking any type of fertility medication or having fertility treatments? **YES / NO**
11) Are you currently breastfeeding? **YES / NO**

MRI systems use strong magnetic fields & radio-frequency energy for imaging the body. Certain implants, devices, objects, and even clothes my pose a hazard to individuals in close proximity to the MRI system and/or interfere with the MRI procedure. The MRI system is always on.

Turn over & complete.

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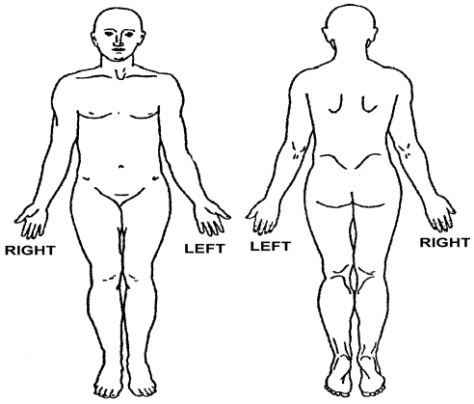
MRI Procedure Screening Questionnaire Continued...

Date: _____/_____/_____ MRN: _____

Please indicate if you have any of the following:

☐Yes ☐No Aneurysm 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/external 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 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 or implants
☐Yes ☐No Swan-Ganz or thermodilution catheter
☐Yes ☐No Medication patch (Nicotine, Nitroglycerine)
☐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 Are you here for an MRI examination?
☐Yes ☐No Dentures or partial plates
☐Yes ☐No Tattoo or permanent makeup
☐Yes ☐No Body piercing jewelry
☐Yes ☐No Hearing aid *(Remove before entering MR system room)*
☐Yes ☐No Other implant _____
☐Yes ☐No Breathing problem or motion disorder

Please mark on the figures below the location of any implants or metal inside of or on your body.



Instructions for the Patient:

1. Remove **ALL** jewelry and **ALL** body piercing jewelry and **ALL** hair/eye lash accessories.

2. Remove dentures, false teeth, partial dental plates, retainers.

3. Remove hearing aids and eyeglasses.

4. Remove **ALL** clothing (to include undergarments) and change into a hospital gown.

5. Please use the restroom before your MRI exam.

6. Please make sure that you receive a pair of earplugs and/or the headphones before your MRI exam begins. Some patients may find the noise levels unacceptable, and the noise levels may affect your hearing.

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.

_____ _____/_____/_____ _____
Patient/Parent/Guardian/RN/MD/Other Signature — Date — Time

_____
Patient/Parent/Guardian/RN/MD/Other Print

_____ _____/_____/_____ _____
Level 2 MRI Personnel Signature — Date — Time