PARK WEST RADIOLOGY

MRI SCREENING SHEET

COMPLETED BY PATIENT

PATIENT NAME: DATE:

DATE OF APPOINTMENT: / / DATE OF BIRTH: / / AGE:

REFERRING PHYSICIAN: PHONE #:

Is this your first MRI? ☐YES ☐NO How much do you weigh? ☐

Date of prior MRI: / /

Have you ever had or have any of the following:

Pacemaker?	☐YES	☐NO	Aneurysm Clips?	☐YES	☐NO
Implanted Cardiac Defibrillator?	☐YES	☐NO	Retinal Tack?	☐YES	☐NO
Cochlear Ear Implants?	☐YES	☐NO			
Implants of any kind?	☐YES	☐NO	If YES, explain:		
Could you possibly be pregnant?	☐YES	☐NO	Date of last menstrual period: / /		

If you answer YES to any of these questions please tell the Technologist prior to your appointment.
If you answer YES to any of these questions, please contact Park West Radiology at 212-874-6362 immediately.

Have you ever worked in a metal or machine shop? ☐YES ☐NO

Have you ever been struck in the eyes with metal shavings? ☐YES ☐NO

If YES, explain:

Foreign bodies (bullets, shrapnel, body piercing)? ☐YES ☐NO

If YES, explain:

Have you ever had:

Cranial surgery? (eg. VP shunt)	☐YES	☐NO	If YES, explain:
Eye surgery?	☐YES	☐NO	If YES, explain:

If you answer YES to any of the above questions please contact Park West Radiology at 212-874-6362 immediately and we will advise you of what additional information is required to ensure your safety during your MRI.

Neck surgery? (eg. Stent)	☐YES	☐NO	If YES, explain:
Chest/Heart surgery? (eg. Cardiac stent)	☐YES	☐NO	If YES, explain:

If you answer YES to the above question and have a stent, you must bring your stent card with you when you come for your procedure. Failure to do so will result in your exam being cancelled.

Anthrosopic surgery?	☐YES	☐NO	If YES, explain:
Any other surgery?	☐YES	☐NO	If YES, explain:

Hearing aid?	☐YES	☐NO	Intrauterine Device/Pessary?	☐YES	☐NO
Dentures/Partials? (including magnetic)	☐YES	☐NO	Tattoo or tattooed eye liner/brow?	☐YES	☐NO
Do you have any allergies?	☐YES	☐NO	If YES, explain:		

If you answer YES to the above question, please call Park West Radiology at 212-874-6362 to be advised of any special instructions in relation to this.

History of Cancer or Tumors?	☐YES	☐NO	If YES, explain:
Have you had radiation therapy?	☐YES	☐NO	If YES, explain:
Chemotherapy?	☐YES	☐NO	If YES, explain:

SCREENED BY: SCREENED WITH:

Technologist comments: Technologist initials:

Additional Notes: MRI Scanner:

I verify that the answers I have provided to questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patients Signature: Date: / /