Cedars Sinai

MRI QUESTIONNAIRE

PATIENT I.D.

Name: _____ MRN: _____ Date of Birth: _____

Age: _____ Height: _____ Weight: _____

Clinical History (Your Symptoms): _____

Duration of Symptoms: _____

INDICATE IF YOU HAVE THE FOLLOWING:

Yes	No	(IF YES, CALL MRI, SERIOUS HAZARDS)
❑	❑	Cardiac Pacemaker: What kind_____
❑	❑	Neurostimulator** / VP Shunt** (**May require reprogramming)
❑	❑	Defibrillator (ICD)/ Swan-Ganz Catheter

Yes	No	May be a SERIOUS hazard or interfere with exam
❑	❑	Claustrophobic
❑	❑	EEG Head Electrodes (May be MRI safe on Inpatient.)
❑	❑	Metal Implant / Postsurgical Hardware
❑	❑	Internal or External Wires
❑	❑	Removable dentures / Hearing aid / Medication patch
❑	❑	Aneurysm clips
❑	❑	Artificial heart valve
❑	❑	Tattoos / Permanent makeup / Hair extensions / Wig
❑	❑	Magnetic / ferromagnetic false / removable eyelashes
❑	❑	Endoscopic clips
❑	❑	Jewelry / Body piercing
❑	❑	Bullet / Shrapnel
❑	❑	Eye implant or injury / Cochlear implant
❑	❑	Prosthetic limb
❑	❑	Implanted drug pump
❑	❑	Injectable Iron replacement medication: When:_____
❑	❑	Breast expander with magnetic port
❑	❑	Intrauterine device (IUD) / Pessary what kind:_____
❑	❑	First day of recent menstrual cycle:_____
❑	❑	MRI contrast within 24 hours

Yes	No	Needs Labs
❑	❑	Inpatient (Creatinine within three days)
❑	❑	High blood pressure requiring medication (For Eovist Only)
❑	❑	Diabetes requiring medication
❑	❑	History of kidney disease (one kidney, kidney cancer, kidney transplant, kidney surgery)
❑	❑	On dialysis. Next scheduled treatment:_____

PLEASE ANSWER THE FOLLOWING:

Yes	No	
❑	❑	Pregnant / suspect you are pregnant
❑	❑	Prior contrast allergy; provide details (If Yes to pregnant or prior MRI contrast allergy; Tech Notify Radiologist and Document)

❑ ❑ **PREMEDICATED for contrast allergy: If YES, answer next four questions and Tech will NOTIFY radiologist and Document:**

- ❑ ❑ Prednisone: 50 mg, PO 13 hrs before exam
- ❑ ❑ Prednisone: 50 mg, PO 7 hrs before exam
- ❑ ❑ Prednisone: 50 mg, 1 hr before
- ❑ ❑ Diphenhydramine: 50 mg, PO in Imaging 30 min before

MRI DEPARTMENT to complete:

Lab Information:

Lab date: _____

Creatinine: _____

GFR: _____

Notify Radiologist if:

- eGFR ≤ 15 Gadovist, Multihance, Doterem
- eGFR < 30 Eovist or Others
- Patient on Dialysis

❑ Screened With Magnetic Detector

❑ Verified MD Order / Protocol / Comments

❑ Reviewed Patient History

❑ Left side ❑ Right side

❑ Bilateral ❑ N/A

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions.

NAME OF PATIENT (please print)	SIGNATURE OF PATIENT	DATE	TIME

NAME OF M.D / R.N. (please print)	TITLE	SIGNATURE OF M.D. / R.N.	DATE	TIME

NAME OF MR TECHNOLOGIST (please print)	TITLE	SIGNATURE OF MR TECHNOLOGIST	DATE	TIME