X-Ray Label

ParkwayHealth™ Radiology

www.parkwayhealthradiology.com.sg

PRE-MRI SCREENING FORM

Date: _____/_____/_____ (dd / mm / yyyy) X-Ray No: _____

Name: _____ (Last name / First name) Height: _____ Weight: _____

Birth Date: _____ NRIC/PP No: _____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ❒ No ❒ Yes
   If yes, please indicate the date and type of surgery:
   Date _____/_____/_____ Type of surgery _____
   Date _____/_____/_____ Type of surgery _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ❒ No ❒ Yes

If yes, please list:	Body part	Date	Facility
MRI	_____	_____/_____/_____	_____
CT/CAT Scan	_____	_____/_____/_____	_____
X-Ray	_____	_____/_____/_____	_____
Ultrasound	_____	_____/_____/_____	_____
Nuclear Medicine	_____	_____/_____/_____	_____
Other _____		_____/_____/_____	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ❒ No ❒ Yes
   If yes, please describe: _____
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 currently taking or have you recently taken any medication or drug? ❒ No ❒ Yes
   If yes, please list: _____
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
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (Kidney) disease, renal (Kidney) failure, renal (Kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease or seizures? ❒ No ❒ Yes
   If yes, please describe: _____
10. Are you claustrophobic ❒ Unsure ❒ No ❒ Yes
11. Do you have any involuntary motion illness ❒ No ❒ Yes

For female patients:

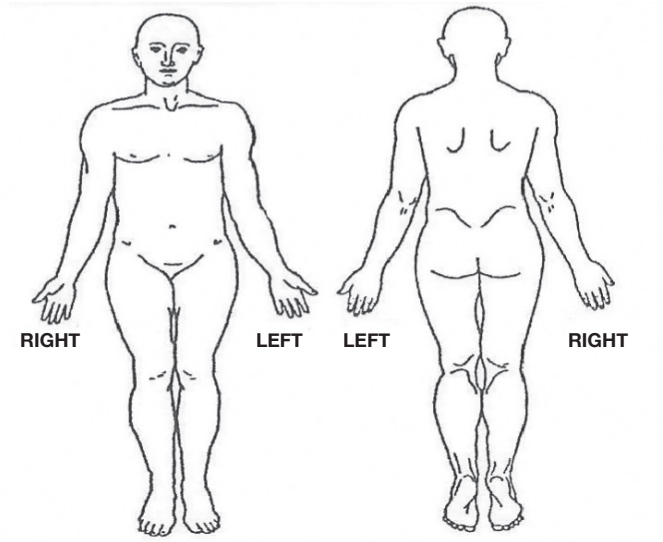
12. Date of last menstrual period: _____/_____/_____ post menopausal? ❒ No ❒ Yes
13. Are you pregnant or experiencing a late menstrual period? ❒ No ❒ Yes
14. Are you taking oral contraceptives or receiving or hormonal treatments? ❒ No ❒ Yes
15. Are you taking any type of fertility medication or having fertility treatments? ❒ No ❒ Yes
    If yes, please describe: _____
16. Are you currently breastfeeding? ❒ No ❒ Yes

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please mark with a check " ✓ " if you have any of the following:

- ❒ Aneurysm clip(s)
- ❒ Cardiac pacemaker
- ❒ Implanted cardioverter defibrillator (ICD)
- ❒ Electronic implant or device
- ❒ Magnetically-activated implant or device
- ❒ Neurostimulation system
- ❒ Spinal cord stimulator
- ❒ Internal electrodes or wires
- ❒ Bone growth/bone fusion stimulator
- ❒ Cochlear, otologic, or other ear implant
- ❒ Insulin or other infusion pump
- ❒ Implanted drug infusion device
- ❒ Any type of prosthesis (eye, penile, etc.)
- ❒ Heart valve prosthesis
- ❒ Eyelid spring or wire
- ❒ Artificial or prosthetic limb
- ❒ Metallic stent, filter, or coil
- ❒ Shunt (spinal or intraventricular)
- ❒ Vascular access port and/or catheter
- ❒ Radiation seeds or implants
- ❒ Swan-Ganz or thermodilution catheter
- ❒ Medication patch (Nicotine, Nitroglycerine)
- ❒ Any metallic fragment or foreign body
- ❒ Wire mesh implant
- ❒ Tissue expander (e.g., breast)
- ❒ Surgical staples, clips, or metallic sutures
- ❒ Joint replacement (hip, knee, etc.)
- ❒ Bone/joint pin, screw, nail, wire, plate, etc.
- ❒ IUD, diaphragm, or pessary
- ❒ Dentures or partial plates
  (Remove before entering MR room)
- ❒ Tattoo or permanent makeup (eyeliner, lips, etc.)
- ❒ Body piercing jewelry
- ❒ Hearing aid
  (Remove before entering MR room)
- ❒ Endoscopic capsule
- ❒ Other implant _____

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

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 radiographer 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 confirm that the above information is correct to the best of my knowledge.

Signature of person completing form: _____ Date _____/_____/_____
Signature

Form Completed By: ❒ Patient ❒ Relative ❒ Nurse _____ _____
Print name Relationship to patient

Interpreted by (if any) _____
Print name

To be completed by MRI facility.

Form Information Reviewed By: _____ _____
Print name Signature

Comments: _____

MRI Ear-Plugs offered by _____ Accepted / Refused