MISSOULA Bone & Joint

MRI Metal Screening

MBJ MR Imaging
2360 Mullan Rd., Suite C
Missoula, MT 59808
(406) 829-5567

Patient Name: _____ **DOB:** ____/____/____ **ID#:** _____

Date of Exam: ____/____/____ **Time of Exam:** _____ **AM / PM** **Ordering Provider:** _____

Exam Type: _____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. **DO NOT ENTER** the MR system room or MR environment if you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist or MRI Assistant BEFORE entering the MR system room. The MR system magnet is **ALWAYS** on.

Please indicate if you have any of the following:

- ❑ **Yes** ❑ **No** **Have you ever had a prior MRI at MBJ** *(1.5 T 1/2013 - current)*
- ❑ **Yes** ❑ **No** **Cardiac Pacemaker**
- ❑ **Yes** ❑ **No** **Pregnancy** - *Date of last period:* _____
- ❑ **Yes** ❑ **No** **Aneurysm clip(s)**
- ❑ Yes ❑ No Claustrophobia - *Pharmacy:*
- ❑ Yes ❑ No Have you ever been a Welder/Grinder? - *X-rays Ordered* ❑ *Yes*
- ❑ Yes ❑ No Any shrapnel, metallic fragment or foreign body - *X-rays Ordered* ❑ *Yes*
- ❑ Yes ❑ No Metallic Stent, Filter or Coil
- ❑ Yes ❑ No Bone/joint pin, screw, nail, wire, plate, etc.
- ❑ Yes ❑ No Surgical staples, clips, or metallic sutures
- ❑ Yes ❑ No Joint replacement (hip, knee, etc.)
- ❑ Yes ❑ No Shunt (spinal or intraventricular)
- ❑ Yes ❑ No Electronic implant or device, ICD, wire mesh or magnetically-activated implant or device
- ❑ Yes ❑ No Insulin or other infusion pump
- ❑ Yes ❑ No Spinal cord stimulator
- ❑ Yes ❑ No Internal electrodes or wires
- ❑ Yes ❑ No Neurostimulation system
- ❑ Yes ❑ No Bone growth/bone fusion stimulator
- ❑ Yes ❑ No Implanted drug infusion device
- ❑ Yes ❑ No Any type of prosthesis (eye, penile, heart, etc.)
- ❑ Yes ❑ No Artificial or prosthetic limb
- ❑ Yes ❑ No Hearing aid (*Remove before entering MR Room)*
- ❑ Yes ❑ No Cochlear, otologic, or other ear implant
- ❑ Yes ❑ No IUD, diaphragm or pessary
- ❑ Yes ❑ No Tissue expander (e.g. Breast, Skin)
- ❑ Yes ❑ No Radiation seeds or implants
- ❑ Yes ❑ No Medication patch (Nicotine, Nitroglycerine)
- ❑ Yes ❑ No Eyelid spring or wire
- ❑ Yes ❑ No Vascular access port and/or catheter
- ❑ Yes ❑ No Swan-Ganz or thermodilution catheter
- ❑ Yes ❑ No Body piercing jewelry (*Remove before entering MR Room)*
- ❑ Yes ❑ No Tattoo or permanent makeup
- ❑ Yes ❑ No Dentures or partial plates

ARTHROGRAM

An _____ guided intra-articular injection of
Imaging Type

the _____ was performed by _____
Joint *Physician*

using _____ CC of a saline and Gadavist mixture.
Amount

IV CONTRAST

_____ CC of _____ with a _____
Amount *Contrast* *GA & Type*

@ _____ X _____ by _____
Time *# of Punctures* *Technologist*

_____ Lot #: _____
Site Location

Expiration Date: _____

Contrast Reaction: ❑ Yes ❑ No

Explain: _____

_____

NOTES / PENDING CLEARANCE

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 the form and regarding the MR procedure that I am about to undergo. I have also been informed of other facilities to receive MRI services.

Patient Signature: _____ **Date:** ____/____/____

Form Information Reviewed By: _____ Date: ____/____/____

❑ MRI Technologist ❑ MRI Assistant

6.6.17 KK