SIOUX FALLS
OPEN-UPRIGHT MRI, LLC
A NATURAL SHIFT IN IMAGING

PATIENT SCREENING FORM

Everyone entering the exam room must complete the following safety screening. Certain items can interfere with or be hazardous to you during the study.

Do you have a cardiac pacemaker, pacer wire or implanted defibrillator? Yes No

Other implanted devices (i.e., insulin pump, infusion pump, intrauterine device)? Yes No

Do you have a middle ear implant (i.e., stapes prosthesis, cochlear implant)? Yes No

Do you have any aneurysm clips in the head or neck? Yes No

Do you have allergies to contrast agents? Yes No

Do you have a history of diabetes, hypertension or kidney/renal disease?
Have you had Renal Failure/Dialysis? ***If yes, have labs been drawn? Yes No*** Yes No

Have you ever had metal particles in your eyes? Yes No
If yes, have you had an MRI since then? Yes No
If not, x-rays must be taken before the MRI can be done to ensure there is no metal remaining.

Do you have artificial heart valves? Yes No

Do you have any type of intravascular coil, filter or stent? Yes No
(i.e., IVC filter, Palmaz stent, umbrella filter, Swan-Ganz catheter)

Do you have any shrapnel or other metal in your body? Yes No
(including bone or joint pins, plates, screws)

Have you had surgery within the past 6 weeks? Yes No

Have you ever had surgery on your spine? Yes No
If Yes, Check one: ____Neck ____Middle back ____Lower back

Are you claustrophobic? (afraid or bothered by small spaces) Yes No

Are you pregnant or a nursing mother? Yes No

Do you have any body piercings (i.e., nose, lip, tongue, eyebrow,
navel, nipple, earrings, etc.)? Tattooed eyeliner? Yes No

Do you have dentures or hearing aides? Yes No

Are you wearing any medicated patches? Yes No

If you answered yes to any of these questions, please offer an explanation.

WARNING: Hearing aides must be removed before entering the procedure room. Please take off all loose jewelry (earrings, necklace, watch and bracelets). Depending on your scan, you may be asked to remove dentures or partial plates.

Signature of Patient _____ Date _____

Printed Name _____

Technologist Signature _____