RADIOLOGY ASSOCIATES of HARTFORD, P.C.

Avon • 35 Nod Road
Enfield • 9 Cranbrook Blvd
Glastonbury • 31 Sycamore Street

Phone: (860) 714-2724
Fax: (860) 714-8808

MRI History and Screening Form

Appt Date ____ / ____ / ____ **Exam (1)** ____________________________ **Exam (2)** ____________________________

Patient Name: ____________________________ **MRN:** ______________ **Date of Birth:** ________________

Physician: ____________________________ **Physician Phone #:** ____________________________

Sex: ☐ **Male** ☐ **Female Height:** ______ **Weight:** ______ **Previous Imaging related to current exam?** ☐ **Yes** ☐ **No** ***Bring CD*** _____

We know the paperwork is inconvenient, but it is necessary to ensure your safety.
Thank you for your assistance and understanding.

List All Previous Surgeries (use other side if necessary): ____________________________

____

Do you have or have you ever had any of the following?

☐ Yes ☐ No Cardiac Pacemaker
☐ Yes ☐ No Implanted Cardiac Defibrillator (ICD)
☐ Yes ☐ No Ear Surgery/Cochlear Implants/Hearing Aids/Stapes Prosthesis: ____________________
☐ Yes ☐ No Electrical/Mechanical/Magnetic Implants? Type: ____________________
☐ Yes ☐ No Neuro-Stimulator/Bio-Stimulator/Bone Growth Stimulator
☐ Yes ☐ No Eye Surgery/Implants/Spring/Wires/Retinal Tack
☐ Yes ☐ No Any Prosthesis/Implant: IUD, Diaphragm, Penile Implant or Pessary, etc… ____________________
☐ Yes ☐ No Implanted Drug Infusion Pump/Insulin Pump: ____________________
☐ Yes ☐ No Breast Tissue Expander
☐ Yes ☐ No Brain Aneurysm Clips/ Brain Surgery: If Yes, explain: ____________________
☐ Yes ☐ No Injury to the Eye Involving Metal or Metal Shavings or Any Metal Injury to Your Body
☐ Yes ☐ No Heart Surgery/Heart Valve: If Yes, explain: ____________________
☐ Yes ☐ No Shunts/Stents/Filters/Intravascular Coil:
☐ Yes ☐ No Gunshot Wounds/Shrapnel/BB: ____________________
☐ Yes ☐ No Tattoo's/Permanent Make-up/Body Piercing/Patches
☐ Yes ☐ No Medication Patches: ____________________
☐ Yes ☐ No Previous Back Surgery (Lumbar/Thoracic/Cervical): When: ____________ Levels: ____________
☐ Yes ☐ No Vascular Access Port/Catheter
☐ Yes ☐ No Metal Mesh Implants/Wire Sutures/Wire Staples or Clips/Internal Electrodes
☐ Yes ☐ No Are you or could you be Pregnant? When was your last Menstrual Period/Cycle? ____________
☐ Yes ☐ No Dentures/Partials/Dental Implants
☐ Yes ☐ No Do you have pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig
☐ Yes ☐ No Are you Claustrophobic? ☐ Yes ☐ No Do you need medication for Claustrophobia?
☐ Yes ☐ No Gastric Reflux Device: *LINX Reflux Management System*
☐ Yes ☐ No Are you taking any Medications, if yes please fill out Medication Reconciliation Form

MRI Contrast History: Have you ever had MRI contrast? ☐ Yes ☐ No
Did you have any kind of reaction? ☐ Yes ☐ No If yes, explain: ____________________
Do you have any history of Renal disease? ☐ Yes ☐ No Are you on Renal dialysis? ☐ Yes ☐ No
Do you have any history of Hypertension? ☐ Yes ☐ No Do you have any history of Diabetes? ☐ Yes ☐ No
eGFR: ____________ List any Allergies: ____________________

I attest that the above information is correct to the best of my knowledge. I have also informed the technologist that I am not pregnant at this time and I give consent to have a contrast agent administered to me if needed for proper diagnosis of my procedure.

Patient/Parent/Legal Guardian Signature ____________________ **Date** ____________
Form Completed by: ☐ Patient ☐ Relative/Friend ☐ Nurse ☐ Clerical ☐ Technologist ☐ Physician

MRI Technologist's Signature: ____________________ **Date** ____________