GUAM RADIOLOGY CONSULTANTS

ADVANCED MRI CENTER

Suite 210, Guam Medical Plaza, Tamuning

PATIENT HISTORY AND SCREENING FOR MRI EXAMS

Please complete this safety form and bring it to our office two days prior to your scheduled exam (except STAT exams). You may fax it to our confidential fax number: 649-1009
Bring the original to your exam. It is important that you read and complete the entire form.

Call 649-1001 if you have questions, need clarification, or have any concerns. If you have not been provided a map, please call for directions or visit our website:

www.guamradiology.com

Have you been given an appointment? ☐ No, not yet ☐ Yes, it is on: _____
Date

Patient: _____
Last name First name Middle Initial

☐ Male

Age:_____ Date of Birth: _____ ☐Female Height_____ Weight_____

Telephone numbers: _____ _____ _____
Home Work Cell

Referring Health Care Provider: _____

Body Part(s) to be Examined: _____

Briefly describe the reason for this MRI exam:

Have you ever had surgery? This includes any operation or procedure including arthroscopy, endoscopy, etc. ☐ No ☐ Yes If yes, please list the date(s) and type(s) of surgery:

Date _____ Type of surgery _____

Date _____ Type of surgery _____

Date _____ Type of surgery _____

Date _____ Type of surgery _____

Please list any other surgical procedures on an additional page.

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Have you had prior imaging studies related to this MRI such as a prior MRI, CAT Scan, Ultrasound, Nuclear Medicine or regular X-Ray Exam: ☐ No ☐ Yes

If yes, please list:

Date _____ Exam _____ _____
Facility

Date _____ Exam _____ _____
Facility

Date _____ Exam _____ _____
Facility

Date _____ Exam _____ _____
Facility

Have you experienced any problem related to a previous MRI examination?

No ☐ Yes ☐ If yes, please describe: _____

Have you had an injury to the eye involving a metallic object / fragment (e.g., metallic slivers, shavings, etc.)? ☐ No ☐ Yes

If yes, please describe: _____

Have you ever been injured by a metallic object or do you have a metallic foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes

If yes, please describe: _____

Have you ever worked as a welder, machinist or in job that could expose you to loose metal fragments? ☐ No ☐ Yes

Are you currently taking any medications or drugs? ☐ No ☐ Yes

If yes, please list:_____

If more room is needed, please use an additional page. _____

Are you allergic to any medication or food? ☐ No ☐ Yes List:_____

Do you have a history of: Asthma? ☐ No Yes ☐ Lung Disease? ☐ No ☐ Yes
A reaction to a contrast dye used for MRI, CT, or an X-ray examination? ☐ No ☐ Yes

Do you have anemia or any disease that affects your blood, a history of renal (kidney) disease, seizures or a motion disorder? ☐ No ☐ Yes

If yes, please describe: _____

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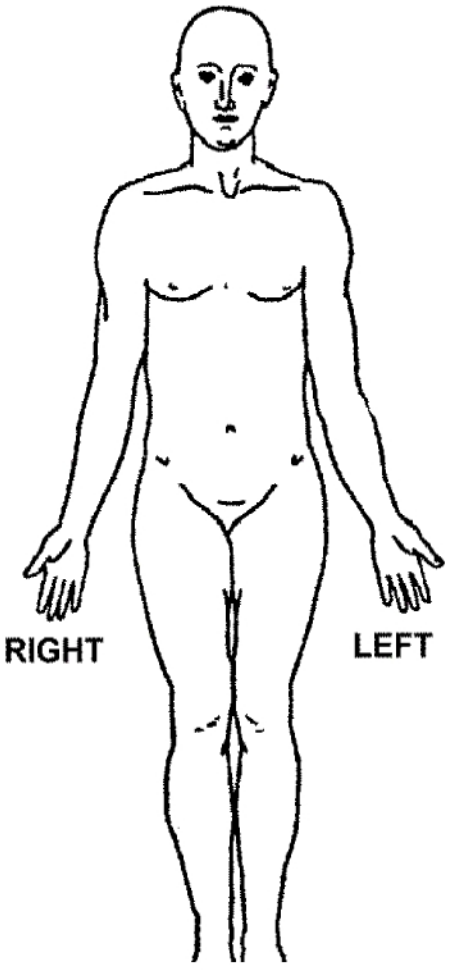
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI procedure. Do not enter the MR system room if you have any questions or concerns, including questions regarding an implant or other medical device. You should consult the MRI Technologist or Radiologist with any concerns BEFORE entering the MR system room . The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- ☐ Yes ☐ No Aneurysm clip(s)
- ☐ Yes ☐ No Cardiac pacemaker
- ☐ Yes ☐ No Implanted cardioverter / defibrillator (ICD)
- ☐ Yes ☐ No Electronic implant or device of any type
- ☐ Yes ☐ No Magnetically activated implant or device
- ☐ Yes ☐ No Neuro or spinal cord stimulator system
- ☐ Yes ☐ No Internal electrodes or wires
- ☐ Yes ☐ No Bone growth or bone fusion stimulator
- ☐ Yes ☐ No Hearing aid
- ☐ Yes ☐ No Cochlear, otologic, or other ear implant
- ☐ Yes ☐ No Insulin or other medicine infusion pump
- ☐ Yes ☐ No Implanted drug infusion device
- ☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)
- ☐ Yes ☐ No Artificial heart valve or heart stent
- ☐ Yes ☐ No Eyelid spring or wire
- ☐ Yes ☐ No Artificial or prosthetic limb
- ☐ Yes ☐ No Metallic stent, filter, or coil of any type
- ☐ Yes ☐ No Shunt (spinal, intraventricular or other)
- ☐ Yes ☐ No Vascular Port access and/or catheter
- ☐ Yes ☐ No Radiation seeds or implants
- ☐ Yes ☐ No Swan-Ganz or thermodilution catheter
- ☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
- ☐ Yes ☐ No Wire mesh implant
- ☐ Yes ☐ No Tissue expander (e.g., breast)
- ☐ Yes ☐ No Surgical staples, clips, or metallic sutures
- ☐ Yes ☐ No Joint replacement (hip, knee, etc.)
- ☐ Yes ☐ No Bone or joint pin, screw, nail, wire, plate, etc.
- ☐ Yes ☐ No IUD, contraceptive diaphragm, or pessary
- ☐ Yes ☐ No Dentures or partial plates
- ☐ Yes ☐ No Tattoo or permanent makeup
- ☐ Yes ☐ No Body piercing jewelry (any type)
- ☐ Yes ☐ No Claustrophobia
- ☐ Yes ☐ No Other implant _____

Please mark on the figure below the location of any implant or metal inside of or on your body - do not include items you can remove, such as earrings / navel rings, etc.



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For female patients:

Are you post menopausal? ☐ No ☐ Yes If no: Date of last menstrual period: _____

Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes

Are you taking birth control pills or any contraceptives ☐ No ☐ Yes List_____

Are you taking any type of fertility or hormonal medication or having fertility treatments?

☐ No ☐ Yes If yes, please describe: _____

Are you currently breastfeeding? ☐ No ☐ Yes

	Before entering the actual MRI room, you will be asked to remove all metallic objects including any hearing aid, dentures, partial plates, keys, beeper, cell phones, eyeglasses, hair pins, barrettes, jewelry - including body piercing jewelry, watch, safety pins, paperclips, money clips, credit cards, bank cards, cards with magnetic strips, coins, pencils, pens, pocket knives, nail clippers, tools, clothing with metal fasteners, & clothing with metallic threads. We will provide you with a gown to wear during the exam and a locked secure storage space for your belongings.

NOTE: The MRI system at Guam Radiology Consultants, produces much less noise than most other MRI units. Although an improvement, the noise during the exam is still rather loud. You will be provided headphones and a choice of music to help drown out the noise. If you prefer ear plugs, they will be provided upon request.

Please consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE you enter the MR system room.

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 this form and regarding the MR procedure that I am about to undergo.

PLEASE DO NOT SIGN THIS FORM UNTIL YOU ARRIVE AT GUAM RADIOLOGY CONSULTANTS

Signature: _____ _____
Patient or legally authorized representative Date

If the signature is not from the patient:

_____ _____ _____
Print name Relationship to patient

Form Reviewed By: _____ _____ _____
Print Name Signature Date

☐ MRI Technologist ☐ Nurse ☐ Radiologist

Print Form