# Longhorn Imaging Metal Screening Form

Patient Name_____ Follow Up Appointment Date__/__/____
D.O.B.___/___/_____ Age:_____ Ht:_____ Weight:_____ Sex: M / F

**Please give a description of your symptoms and date of injury.**

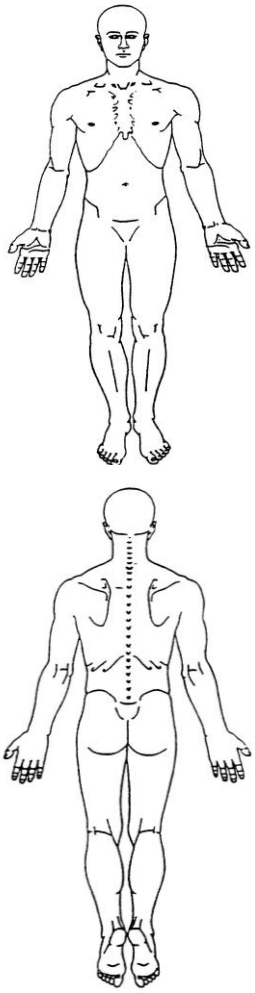
_____
_____

How were you injured? ___Work ___ Motor Vehicle Accident ___ Other _____
Have you taken any sedation for your exam today? Yes__No__ What type/Time_____

**Please indicate if you have the following: (Please read and check each line)**

__ Yes __No Cardiac Pacemaker
__ Yes __No Implanted Cardio Defibrillator (ICD)
__ Yes __No Aneurysm Clip or Coil _____
__ Yes __No Electronic implanted device_____
__ Yes __No Neurostimulation system or spinal cord stimulator
__ Yes __No Bone growth/bone fusion stimulator
__ Yes __No Internal electrodes or wires
__ Yes __No Implanted drug infusion device_____
__ Yes __No Insulin or other infusion pump_____
__ Yes __No Cochlear, otologic, or other ear implant_____
__ Yes __No Heart valve prosthesis
__ Yes __No Any Type of prostesis (eye, penile, ect)_____
__ Yes __No Eyelid spring or wire
__ Yes __No Artificial or prosthetic limb
__ Yes __No Metallic stent, filter, or coil_____Date implanted__ /__/____
__ Yes __No Shunt (spinal or intraventricular)_____
__ Yes __No Vascular access port and/of catheter
__ Yes __No Radiation seeds or implants
__ Yes __No Swan-ganz or thermodilution catheter_____Date implanted__ /__/____
__ Yes __No Medication patch (nicotine, Nitroglycerine) _____
__ Yes __No Any metallic fragment or foreign body_____
__ Yes __No Wire mesh implant
__ Yes __No Tissue Expander (e.g. breast)
__ Yes __No Surgical staples, clips, or metallic sutures_____
__ Yes __No Joint replacments ___Hip___knee___Other_____
__ Yes __No Bone/Joint pin, screw, nail, wire, plate, ect.
__ Yes __No IUD, diaphragm, or pessary
__ Yes __No Dentures or partial plates
__ Yes __No Tattoo or permanent makeup, or body piercing jewelry
__ Yes __No Hearing aid
__ Yes __No Other implant not listed above_____
__ Yes __No Claustrophobia If yes what meds did your doctor perscribe_____
__ Yes __No Any chance that you may be pregnant? Last menstrual period/cycle__/__/____
__ Yes __No Have you ever had an injury to your eye involving metal or metal shavings

***Please Indicate where your pain is located:



**Please list any allergies_____**
**Please list any previous surgeries_____**
**Please list any medications you're presently taking_____**

**MRI Contrast History**

Have you ever received an injection of MRI contrast in the past? __Yes __No
Did you have any kind reaction? __Yes __No
Are you breast feeding at this time? __Yes __No
*** Do you have any history of Renal Disease? __Yes __No
*** Do you have any history of hypertension? __Yes __No
*** Do you have any history of Diabetes? __Yes __No
Have you ever had severe hepatic disease or liver transplant or pending liver transplant __Yes __No

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**X**_____ _____ **Date __/__/____**
Patient/Parent/Legal Guardian MRI Technologist's Signature

**IMPORTANT INSTRUCTIONS**

Before entering the MR environment of MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, cell phones, 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, and clothing with metallic threads. You will be given your very own room to secure your belongings in. Please lock the door and take the key with you. (The key is MRI safe and you can keep it in the room with you.)