OPEN SKIES MRI

SCREENING FORM
LABEL GOES HERE

MRI PATIENT HISTORY/SCREENING FORM

Do you have any of the following items in / on your body? (please mark ***yes*** or ***no***)

YES	NO		YES	NO	
_____	_____	Cardiac Pacemaker/Pacing Wires	_____	_____	Implanted Drug Infusion Device
_____	_____	Cardiac Stent	_____	_____	Bone Growth Stimulator
_____	_____	Vascular Clip, including Aneurysm Clip	_____	_____	Neurostimulator
_____	_____	Heart Valve Prosthesis	_____	_____	Any type of Biostimulator
_____	_____	Sternal wires (open heart surgery)	_____	_____	Implanted Insulin Pump
_____	_____	Intravascular Coils	_____	_____	Any type of surgical clip / staple
_____	_____	Swan-Ganz Catheter	_____	_____	Middle Ear Implant, incl. Cochlear implant
_____	_____	Vena Cava Filter	_____	_____	Penile Prosthesis
_____	_____	PICC Line or PermaCath / PortaCath	_____	_____	Eye Prosthesis
_____	_____	Automatic Cardiac Defibrillator	_____	_____	Metallic Shrapnel
_____	_____	Renal Stent	_____	_____	Any Orthopedic items (ie: pins,
_____	_____	Intraventrical Shunt			screws, plates, artificial limb or joint)

***** Please notify the technologist if you have any of the following: Hearing Aid, Piercings, Tattoos, Diaphragm or Intrauterine Device (IUD), Skin Patch (e.g. nitro, morphine, nicotine, contraception, etc.)**

Are you on any blood thinner medication? **YES** **NO** Med: _____

Have you ever had any endoscopic procedure? **YES** **NO** Date: _____

Have you ever had any operation or vascular procedure including stent placement? **YES** **NO**

Type: _____ Year: _____ Type: _____ Year: _____

Type: _____ Year: _____ Type: _____ Year: _____

Type: _____ Year: _____ Type: _____ Year: _____

Have you **EVER** been subjected to small metal slivers in your eyes? Yes ____ No ____

Are you pregnant or do you suspect that you may be pregnant? Yes ____ No ____

Your approximate weight? _____ lbs kg (circle)

The information above is accurate to the best of my knowledge.

_____ _____

Signature of Patient or Guardian of Patient Date

_____ I authorize Open Skies MRI to release my MRI results to any health care professional who is currently involved with my care or may be in the future.

_____Signature of Witness (MRI Technologist)