WYOMING COUNTY COMMUNITY HEALTH SYSTEM

Warsaw, New York 14569

NAME: _____ DATE: _____

SEX: _____ AGE: _____ HEIGHT: _____ WEIGHT_____

The following items may be harmful to you during your MR scan or may interfere with the MR examination. Please provide a "yes" or "no" answer for every item.

YES	NO	
☐	☐	Cardiac pacemaker or implanted cardioverter defibrillator/ICD
☐	☐	Internal electrodes or wires (pacing wires, DBS or VNS wires)
☐	☐	Artificial heart valve, coil, filter and/or stent (Gianturco coil, IVC filter)
☐	☐	Aneurysm clip(s) anywhere in your brain or body
☐	☐	Neurostimulator-TENS Unit, Biostimulator, bone growth stimulator, DBS, VNS
☐	☐	Implanted drug pump (e.g., insulin, chemotherapy, pain medicine
☐	☐	IV access port (Port-a-Cath, Broviac, PICC line, Swan-Gantz, Thermodilution
☐	☐	Implanted post-surgical hardware (pins, rods, screws, plates, wires)
☐	☐	Artificial joint and/or limb
☐	☐	Artificial eye and/or eyelid spring
☐	☐	Eye injury from a metal object (metal shavings, metal slivers)
☐	☐	Ear (Cochlear) implant, middle ear implant
☐	☐	Hearing aid(s)
☐	☐	False teeth/dentures, metallic removable dental work, braces, retainers
☐	☐	Any type of implant held in place by a magnet
☐	☐	Injured by a metal object (shrapnel, bullet, B.B.)
☐	☐	Medication patch (nitroglycerine, nicotine, contraceptive, estrogen)
☐	☐	Shunt or Sophy adjustable and programmable pressure valve
☐	☐	Spinal fixation device, spinal fusion and/or halo vest, spinal cord stimulator
☐	☐	Surgical clips, staples or surgical mesh
☐	☐	Tissue expander (breast)
☐	☐	Penile implant
☐	☐	Pessary, IUD, Diaphragm
☐	☐	Radiation seeds (cancer treatment)
☐	☐	Body piercing, tattoo, or permanent makeup
☐	☐	Wig, hair implants

(Over)

DO YOU HAVE A HISTORY OF?

YES	NO		YES	NO	
☐	☐	Kidney Disease	☐	☐	Claustrophobia
☐	☐	Diabetes	☐	☐	Drug allergy Type_____
☐	☐	High blood pressure	☐	☐	Latex allergy
☐	☐	Congestive heart failure	☐	☐	Allergic reaction to MRI contrast
☐	☐	Liver disease			(Gadolinium based, Feridex)

Have you had prior surgery or an operation of any kind? ☐ No ☐ Yes

If yes, please indicate the date and type of surgery:

Date: ____/____/____ Type of surgery _____

Date: ____/____/____ Type of surgery _____

Have you ever been treated for any type of cancer? ☐ No ☐ Yes

If yes what type _____

Are you on dialysis? ☐ YES ☐ NO If YES Hemodialysis or Peridialysis? (Circle one)

FEMALE PATIENTS:

Are you pregnant? ☐ YES ☐ NO Are you breast feeding? ☐ YES ☐ NO

If you are still menstruating, please provide the date of your last period: _____

If you answered **YES** to any of the above questions, please discuss any concerns and/or issues you may have with the MR Technologist prior to your examination.

 IMPORTANT INSTRUCTIONS 

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, guns, coins, pens, pocket knife, nail clipper, tools, weapons of all kinds, clothing with metal fasteners, & clothing with metallic threads such as Under Armour, Lululemon and Tommie Copper.

I attest 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.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

_____ _____

TECHNOLOGIST SIGNATURE DATE

DO YOU HAVE A HISTORY OF?

YES	NO		YES	NO	
☐	☐	Kidney Disease	☐	☐	Claustrophobia
☐	☐	Diabetes	☐	☐	Drug allergy Type_____
☐	☐	High blood pressure	☐	☐	Latex allergy
☐	☐	Congestive heart failure	☐	☐	Allergic reaction to MRI contrast (Gadolinium based, Feridex)
☐	☐	Liver disease			

Have you had prior surgery or an operation of any kind? ☐ No ☐ Yes
If yes, please indicate the date and type of surgery:
Date: ____/____/____ Type of surgery _____
Date: ____/____/____ Type of surgery _____

Have you ever been treated for any type of cancer? ☐ No ☐ Yes
If yes what type _____

Are you on dialysis? ☐ YES ☐ NO If YES Hemodialysis or Peridialysis? (Circle one)

FEMALE PATIENTS:
Are you pregnant? ☐ YES ☐ NO Are you breast feeding? ☐ YES ☐ NO
If you are still menstruating, please provide the date of your last period: _____

If you answered **YES** to any of the above questions, please discuss any concerns and/or issues you may have with the MR Technologist prior to your examination.

IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, guns, coins, pens, pocket knife, nail clipper, tools, weapons of all kinds, clothing with metal fasteners, & clothing with metallic threads such as Under Armour, Lululemon and Tommie Copper.

I attest 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.

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

_____ _____
TECHNOLOGIST SIGNATURE DATE

WYOMING COUNTY COMMUNITY HEALTH SYSTEM

Warsaw, New York 14569

NAME: _____ DATE: _____

SEX: _____ AGE: _____ HEIGHT: _____ WEIGHT_____

The following items may be harmful to you during your MR scan or may interfere with the MR examination. Please provide a "yes" or "no" answer for every item.

YES	NO	
☐	☐	Cardiac pacemaker or implanted cardioverter defibrillator/ICD
☐	☐	Internal electrodes or wires (pacing wires, DBS or VNS wires)
☐	☐	Artificial heart valve, coil, filter and/or stent (Gianturco coil, IVC filter)
☐	☐	Aneurysm clip(s) anywhere in your brain or body
☐	☐	Neurostimulator-TENS Unit, Biostimulator, bone growth stimulator, DBS, VNS
☐	☐	Implanted drug pump (e.g., insulin, chemotherapy, pain medicine
☐	☐	IV access port (Port-a-Cath, Broviac, PICC line, Swan-Gantz, Thermodilution
☐	☐	Implanted post-surgical hardware (pins, rods, screws, plates, wires)
☐	☐	Artificial joint and/or limb
☐	☐	Artificial eye and/or eyelid spring
☐	☐	Eye injury from a metal object (metal shavings, metal slivers)
☐	☐	Ear (Cochlear) implant, middle ear implant
☐	☐	Hearing aid(s)
☐	☐	False teeth/dentures, metallic removable dental work, braces, retainers
☐	☐	Any type of implant held in place by a magnet
☐	☐	Injured by a metal object (shrapnel, bullet, B.B.)
☐	☐	Medication patch (nitroglycerine, nicotine, contraceptive, estrogen)
☐	☐	Shunt or Sophy adjustable and programmable pressure valve
☐	☐	Spinal fixation device, spinal fusion and/or halo vest, spinal cord stimulator
☐	☐	Surgical clips, staples or surgical mesh
☐	☐	Tissue expander (breast)
☐	☐	Penile implant
☐	☐	Pessary, IUD, Diaphragm
☐	☐	Radiation seeds (cancer treatment)
☐	☐	Body piercing, tattoo, or permanent makeup
☐	☐	Wig, hair implants

(Over)