HOSPITAL SULTAN ABDUL AZIZ SHAH
UNIVERSITI PUTRA MALAYSIA
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MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM
RADIOLOGY DEPARTMENT

PATIENT DETAILS (Kindly stick patient sticker)	**APPOINTMENT**			
Name : MRN : Age : Height : cm Weight : kg	**APPOINTMENT CATEGORY**	**URGENT**	EARLY	NORMAL
	Request Date			
	Appointment Date			
	Referring Physician			
Indication				

1. Have you had prior surgery or an operation (e.g.arthroscopy, endoscopy,etc.) If yes, please indicate the date and type of surgery: Date: ___/___/_____ Type of surgery:_____ Date: ___/___/_____ Type of surgery:_____	☐No☐Yes
2. Have you had a prior diagnostic imaging study or examination (MRI,CT,Ultrasound X-Ray ,etc.)? If yes, please list: Body Part / Date / Facility MRI _____ ___/___/_____ _____ CT/CAT Scan _____ ___/___/_____ _____ X-Ray _____ ___/___/_____ _____ Ultrasound _____ ___/___/_____ _____ Nuclear Medicine _____ ___/___/_____ _____ Other_____ _____ ___/___/_____ _____	☐No☐Yes
3. Have you experienced any problem related to a previous MRI examination or MR procedure? If yes, please describe:_____	☐No☐Yes
4. Have you had an injury to the eye involving a metallic object or fragment (e.g,metallic slivers, shavings,foreign body,etc)? If yes, please describe:	☐No☐Yes
5. Have you ever been injured by a metallic object or foreign body (e.g, BB, bullet, shrapnel, etc.) If yes, please describe:	☐No☐Yes
6. Are you currently taking, or have you recently taken any medication or drug? If yes, please list:	☐No☐Yes
7. Are you allergic to any medication? If yes, please list:	☐No☐Yes
8. Do you have a history of asthma, allergic reaction,respiratory disease, or reaction to a contrast medium used for MRI, CT or any radiology examination?	☐No☐Yes
9. Do you have anaemia or any disease(s) that affects your blood, a history of renal (kidney) disease,renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes,or seizures? If yes, please list:	☐No☐Yes
For female patients:	
1. Date of last menstrual period:___/___/_____ Post menopausal?	☐No☐Yes
2. Are you pregnant or experiencing a late menstrual period?	☐No☐Yes
3. Are you taking oral contraceptives or receiving hormonal treatments?	☐No☐Yes
4. Are you taking any type of fertility medication or having fertility treatments? If yes, please list:	☐No☐Yes
5. Are you currently breastfeeding?	☐No☐Yes

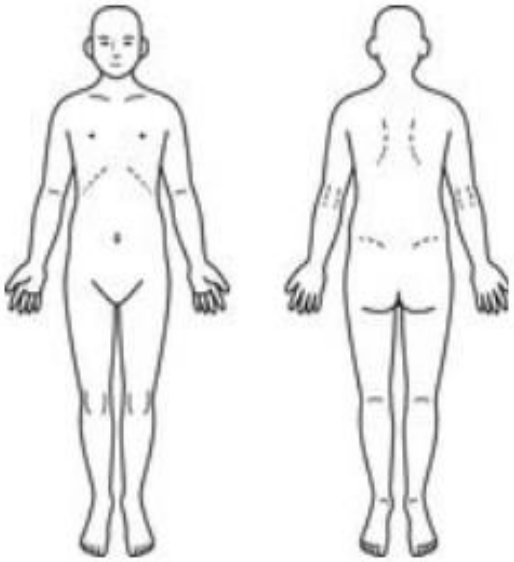
WARNING: Certain implants,devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e MRI, MR angiography, functional MRI,MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Radiographer or Radiologist BEFORE entering the MR system room. The MR system magnet is **ALWAYS** on.

***Please fill form *Special Consent Implant Patient for MRI Procedure* if Patient have Implant**

Please indicate if you have any of the following:

☐Yes ☐No Aneurysm clip(s)
☐Yes ☐No Cardiac pacemaker / Implanted cardioverter defibrillator (ICD)
☐Yes ☐No Heart valve prosthesis
☐Yes ☐No Electronic/Magnetically activated implant or device
☐Yes ☐No Neurostimulation system
☐Yes ☐No Internal electrodes or wires
☐Yes ☐No Bone growth/bone fusion/spinal cord stimulator
☐Yes ☐No Cochlear, otologic, or other ear implant
☐Yes ☐No Insulin or other implanted drug infusion pump/device
☐Yes ☐No Any type of prosthesis(eye,penile,etc.)
☐Yes ☐No Artificial or prosthetic limb
☐Yes ☐No Metallic stent, filter, or coil
☐Yes ☐No Shunt (spinal or intraventricular)
☐Yes ☐No Vascular access port and/or catheter
☐Yes ☐No Radiation seeds or implants
☐Yes ☐No Swan-Ganz or thermodilution catheter
☐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 replacement (hip,knee,etc.)
☐Yes ☐No Bone/joint pin, screw, nail,wire,plate, etc.
☐Yes ☐No IUD, diaphragm, or pessary
☐Yes ☐No Dentures or partial plates
☐Yes ☐No Eyelid spring or wire/Tattoo/permanent makeup
☐Yes ☐No Body piercing jewellery/Hearing aid (remove before entering MRI system room)
☐Yes ☐No Other implant_____
☐Yes ☐No Breathing problem/motion disorder

Please mark on the figure(s) below the location of any implant or metal inside of or on your body



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove <u>all</u> metallic object including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewellery, body piercing jewellery, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocketknife, nail clipper, tools, clothing with metal fasteners/metallic threads.

Please consult the MRI Radiographer or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understood 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.

Signature of Person Completing Form: ☐ Specialist / Medical Officer (Primary Doctor)

_____ Date: ____/____/_____

Form Completed by:☐ Patient ☐ Relative ☐ Nurse

_____ _____
Name Relationship to patient

Form Reviewed by :☐ MR Radiographer ☐ Radiology MO / Radiologist

Signature :_____ _____