BERMUDA HEALTHCARE SERVICES

19 THE LANE
PAGET PG 05
BERMUDA

PHONE: 441-236-2810
FAX: 441-236-5569
EMAIL: INFO@BHCS.BM
WEB: WWW.BHCS.BM

MRI SCREENING FORM

Name_____ Weight_____ Height_____ Date_____

Y or N

- ☐ ☐ Have you ever worked with welding, metal grinding or brakes?
- ☐ ☐ Have you ever had a penetrating injury to your eye involving a metallic object? __L __R
- ☐ ☐ If metal was in your eye, was it removed by a doctor?
- ☐ ☐ Do you have tattoos or permanent eyeliner?
- ☐ ☐ Do you have Occular Implants?
- ☐ ☐ Are you currently pregnant or breast feeding?
- ☐ ☐ Have you had the following? *(check those that apply)* __Cardiac pacemaker __Pace wires __Cardiac catheter __Cardiac loop recorder
- ☐ ☐ Implanted cardiac defibrillator (ICD)?
- ☐ ☐ Cardiac stent (within last 4 weeks)?
- ☐ ☐ Brain Surgery? When? Where? Type?
- ☐ ☐ Brain aneurysm clip(s)? When? Where?
- ☐ ☐ Carotid artery vascular clamp? When? Where?
- ☐ ☐ Cochlear and/or staples implants? When?
- ☐ ☐ Shunt (intraventricular or spinal)?
- ☐ ☐ Insulin or infusion pump (internal/external?
- ☐ ☐ Bone growth/fusion stimulator?
- ☐ ☐ Neurostimulators (Deep Brain Vagus Nerve or Bladder Stimulators)?
- ☐ ☐ Any prosthesis (penile, artificial limb, or breast expanders)?
- ☐ ☐ Joint replacement, screws, pins, rods, staples, metal sutures, mesh implants?
- ☐ ☐ Do you have a __Hearing aid (external or implanted) __Magnetic dentures __Transdermal patch
- ☐ ☐ Swan Ganz Line (internal only)?
- ☐ ☐ Do you have any shrapnel (bullets) in your body?
- ☐ ☐ Do you have Claustrophobia? If yes, are meds ordered for this?
- ☐ ☐ Do you have Asthma or Allergies? Have you had a previous reaction to MRI Contrast (Gadolinium)?
- ☐ ☐ Are you on Dialysis?
- ☐ ☐ Do you have connective tissue disorder?
- ☐ ☐ Small bowel endoscopy capsule?

Signature of PATIENT or Guardian:_____ Date_____

Please fax this screening form along with the MD order and reason for exam to MRI at 236-5569