Centra
All Facilities

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Name: _____ Height: _____ Weight: _____
Last Name First Name Middle Initial

Date of Birth: ___/___/_____ Body Part to be Examined: _____

Reason for MRI, Symptoms, Injury and Date: _____

Referring Physician: _____ Creatinine: _____ GFR: _____ Date Collected: _____

Technologist Use: IV started by: _____ Location: _____ # of sticks: _____ Medications Reviewed ☐ _____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☐ No ☐ Yes
   If yes, please indicate the date and type of surgery:

   Date ___/___/_____ Type of surgery _____
   Date ___/___/_____ Type of surgery _____
   Date ___/___/_____ Type of surgery _____
   Date ___/___/_____ Type of surgery _____

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.) of body part being scanned today?
   If yes, please list:

Exam and Body Part	Date	Facility
_____	Date ___/___/_____	_____
_____	Date ___/___/_____	_____
_____	Date ___/___/_____	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes
   If yes, please describe: _____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ No ☐ Yes
   Technologist Use: Orbits Cleared by: _____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes
   If yes, please describe: _____
6. Do you have a history of cancer? If yes, please describe: _____ ☐ No ☐ Yes
   _____
7. Do you have a history of allergic reaction to a contrast medium or dye used for an MRI examination? ☐ No ☐ Yes
   If yes please describe: _____
8. Do you have a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant? ☐ No ☐ Yes
   If yes please describe: _____

For male patients:

9. Do you have a penile implant? ☐ No ☐ Yes

For female patients:

10. Date of last menstrual period: ___/___/_____ Post menopausal? ☐ No ☐ Yes
11. Are you pregnant or suspect you are pregnant ☐ No ☐ Yes
12. Are you currently breastfeeding? Please note if contrast used, a minimal amount enters the breast milk. ☐ No ☐ Yes

Please fax completed forms to:
Lynchburg General Hospital (434) 200-2696
Southside Community Hospital (434) 315-2768
Bedford Memorial Hospital (540) 586-0317
Gretna Medical Center (434) 200-4541

Patient Label

Not part of the permanent medical record