Dartmouth-Hitchcock MEDICAL CENTER

# MRI Questionnaire

***To Schedule MRI***
***Call (603) 650-8445***

**Scan Date:** _____ **Scan Time:** _____

**Patient Name:** _____

**MRN:** _____

**Age:** _____ **DOB:** _____

**Answers provided by:** Patient / Family Member ***(circle one)***

Body Part to be examined _____

Referring Provider: _____ Office phone/Secretary: _____

**MRI RISKS** ***(Please ask the Patient ALL of the following questions)***

What is the patients current weight?

| | | | | |
|---|---|---|---|---|
| Has the patient had a previous MRI study with injection of Gadolinium? | Yes | | No | |
| Does patient have difficulty breathing or pain while lying flat? | Yes | | No | |
| Does patient need assistance to stand? | Yes | | No | |
| Does patient have mobility limitations? (e.g. spinal precautions) Please List: | Yes | | No | |
| Is patient claustrophobic? | Yes | | No | |
| Has patient ever required sedation or anesthesia for an MRI? | Yes | | No | |
| Does patient have a history of diabetes? | Yes | | No | |
| Does patient have a history of kidney failure? | Yes | | No | |
| Is patient on dialysis? | Yes | | No | |
| If on dialysis, has the dialysis unit been contacted? | Yes | | No | |
| Does patient have a history of metal work/welding? | Yes | | No | |
| Does patient have metal fragments in eyes/body? | Yes | | No | |
| Does patient have body piercings? | Yes | | No | |
| Does the patient have a tattoo, permanent eye liner or metallic nail polish? | Yes | | No | |
| Is the patient wearing any medication patches | Yes | | No | |
| Does the patient have braces, permanent retainers or dentures? | Yes | | No | |
| Has patient had surgury to the area being scanned? | Yes | | No | |
| Is the patient pregnant? | Yes | | No | |
| Is the patient over 70 or over 50 and diabetic? ***If yes, Creatinine level taken within 90 days is required. *Note Below*** | Yes | | No | |

**DOES PATIENT HAVE ANY OF THE FOLLOWING?**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Pacemaker and/or Defribrillator | Yes | | No | | Aneurysm clip | Yes | | No | |
| Spinal Cord Stimulator | Yes | | No | | Vagus Nerve Stimulator | Yes | | No | |
| Cochlear ear implant/other ear implant | Yes | | No | | Other implanted metal/device (specify in comments) | Yes | | No | |

**PROVIDE MAKE/MODEL NUMBERS FOR ANY IMPLANTED DEVICES** _____

_____

**ADDITONAL INFORMATION:** _____

**Questionnaire Completed By:** _____ **Date:** _____