OPA ORTHO
ORTHOPEDIC PHYSICIAN ASSOCIATES

MRI Procedure Screening Form

MRI Suite · 900 Terry Ave, Suite 100 · Seattle, WA 98104
MAIN: (206) 694-6665

The following items may be hazardous or may interfere with the MRI examination.
Please read each item carefully before marking your response.

REMOVE ALL PUMPS AND JEWELRY

Yes	No	
◯	◯	Prior MRI examinations: type, date and place _____
◯	◯	Any procedures or implants since last MRI scan
◯	◯	Tattoos using metal oxides e.g., permanent eyeliner
◯	◯	Any type of surgical clip or staples
◯	◯	Vascular access port
◯	◯	Intraventricular shunt
◯	◯	Artificial Limb ◯ Knee ◯ Hip ◯ Other ____
◯	◯	Any other implanted items (body piercings) Type/location: _____
◯	◯	◯ Dentures ◯ Hearing Aid (MUST REMOVE)
◯	◯	Diagnosed or treated for cancer _____
◯	◯	Transdermal patch (nicotine, nitroglycerine, etc.)

Weight: _____ **Must list weight—Maximum: 500 pounds.**
Must be ambulatory

Yes	No	
◯	◯	**EVER** had metal fragments in your eyes
◯	◯	Any type of foreign body, shrapnel or bullet
◯	◯	Heart valve prosthesis—type: _____
◯	◯	Aneurysm clip(s)—date: _____ hospital: _____
◯	◯	Penile prosthesis—type: _____
◯	◯	Are you, or do you suspect pregnancy
◯	◯	Intravascular coil, filter or stent—type & date implanted: _____
◯	◯	Any type of ear implant—type: _____
◯	◯	Halo vest or metallic cervical fixation device
◯	◯	Any other implanted items—type: _____
◯	◯	Are you claustrophic
◯	◯	Able to hold still on your back for at least 30 minutes
◯	◯	Implanted pumps/drug infusion devices

Mark all blanks, if any marked yes, exam CANNOT be performed, cancel procedure and notify referring clinician.

Yes	No	
◯	◯	Do you or have you had a cardiac pacemaker
◯	◯	Implanted cardiac defibrillator
◯	◯	Internal elctrodes (e.g., retained pacer wires)
◯	◯	Electronic, mechanical, or magnetic implant
◯	◯	Implanted biostimulator or tens unit
◯	◯	Cochlear (inner ear) implant

PLEASE LIST BELOW ALL OPERATIONS & DATES:

_____

_____

_____

_____

EXAM
DATE/TIME

The MRI procedure you have been scheduled for may require the intravenous injection of a non-iodinated contrast solution. It is used to enhance the ability of MRI to facilitate diagnosis. While there are no known contraindications, mild side effects (nausea, headache) may occur. This solution is not the same used for CT scans, IVPs, or angiography.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of, and hereby give consent to have a Magnetic Resonance Image Scan.

Patient Signature: _____ Date: _____

Patient Printed Name: _____ Date: _____

RT/Initials: _____ Date: _____