

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

MR #: \_\_\_\_\_

**University of Wisconsin Hospital and Clinics**

600 Highland Avenue • Madison, Wisconsin 53792

**UW HEALTH MRI SCREENING FORM**

FAX: UWHC 608-262-0907 Research Park 608-265-8330

**Please Fax within 24 hours of scheduling**

Additional Clinic Locations: UW Health 1 South Park • 1 South Park Street • Madison, WI 53715 UW Health Research Park • 621 Science Drive • Madison, WI 53711

The information listed below is important to answer correctly to assure patient compatibility and safety in the MRI scanner.

**Scan Requested** \_\_\_\_\_ **Ordering MD/Telephone** \_\_\_\_\_

**DX** \_\_\_\_\_ **PT WT:** \_\_\_\_\_ **HT:** \_\_\_\_\_ **Appt. Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Yes No**

- Previous MRI  
Date \_\_\_\_\_  
Facility \_\_\_\_\_
- Surgery within last 6 weeks
- Heart Surgery
- CABG
- Heart Valve
- Stent
- Pacemaker/Defibrillator
- Head/Brain Surgery
- Brain Aneurysm Clips
- Coils
- VP Shunts
- Eye Surgery
- Lens Implant
- Ear Surgery
- Ear Implant
- Back Surgery; Location: \_\_\_\_\_
- Implanted Devices
- Breast/Penile
- Electrodes
- Pump
- Epidural Catheters
- Transdermal Patch
- Neurostimulator
- IVC Filters
- Stents
- IUD
- Other

**History of Metal in Body:**

**Yes No**

- Occupational/hobby metal grinder/welder
- Routinely wore safety glasses
- Metal fragments removed from eyes
- Orbit X-rays/Date/Results: \_\_\_\_\_

**Comment on any YES:**

Date \_\_\_\_\_  
 Facility \_\_\_\_\_  
 Physician \_\_\_\_\_  
 Surgical Procedure \_\_\_\_\_  
 Implant Name \_\_\_\_\_  
 Model#/Manufacturer \_\_\_\_\_

**History of Metal in Body: (continued)**

**Yes No**

- Gun Shot, BB's, Shrapnel
- Metal from Accident
- Metal from Surgery
- Tattoo
- Body Piercing

**Provide Information for the following:**

**Yes No**

Kidney Disease \_\_\_\_\_  
 Date: \_\_\_\_\_ BUN: \_\_\_\_\_ mg/dL Date: \_\_\_\_\_ Creatinine: \_\_\_\_\_ mg/dL

Adult Reference Range:  UWHC: 7-20 Adult Reference Range:  UWHC: 0.6-1.3

Check Testing site  UWMF: 7-23 Check Testing site  UWMF: 0.4-1.1

Fill in Ref range for non-UW site  Other: \_\_\_\_\_ Fill in Ref range for non-UW site  Other: \_\_\_\_\_

- Dialysis (days \_\_\_\_\_)
- Physical/Medical/Mental Disabilities \_\_\_\_\_
- Involuntary Motion Disorder \_\_\_\_\_
- Lung Disease
- Sleep Apnea
- Pt. Can lie flat on back and hold still for 30-60 min.
- Pregnancy/Chance of Pregnancy  
Pregnancy Test Results \_\_\_\_\_ Date \_\_\_\_\_
- Breast-feeding
- Claustrophobic
- Sedation Ordered; If yes, identify:  
Drug/Dosage \_\_\_\_\_
- Driver Confirmed
- Pain Medication Ordered; If yes, identify:  
Drug/Dosage \_\_\_\_\_
- Drug Allergies \_\_\_\_\_

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Inpatients Only:	Dobhoff Removed	Y	N	NA
Monitoring Equipment: _____	Pt. Can breath hold for 30 sec.	Y	N	NA
Swan-Ganz Catheter Removed	(Chest and Abdomen MRI/MRA only)			
Y N NA	Isolation: (Type) _____			

**SCREENER/FORM COMPLETED BY (Signature/Date Required):** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**INFORMATION SOURCE: Patient / Chart / Family Member** \_\_\_\_\_ **/ Other** \_\_\_\_\_

**MRI/RN** \_\_\_\_\_ **MRI Tech** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Pager #:** \_\_\_\_\_