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| --- | --- |
|  | MAGNETIC RESONANCE CONTRAST SCREENING FORM |
| **magnet** | This MR system has a very strong static field that may be hazardous to individuals entering the magnet room if they have certain metallic, electronic, magnetic, or mechanical implants, devices or objects. Therefore, all individuals are required to fill out this form BEFORE entering the magnet room. Be advised, the magnet is ALWAYS ON. |

**Please complete if you are scheduled to have an injection of MRI contrast media:**

On-Call Physician:       Pager Number:

 Print Name

|  |  |
| --- | --- |
| [ ] Yes [ ] No | Have you had a previous MRI with contrast dye? |
| [ ] Yes [ ] No | Have you ever had a reaction to x-ray contrast? |
| [ ] Yes [ ] No | Do you have sickle cell anemia? |
| [ ] Yes [ ] No | Do you have a history of asthma? |
| [ ] Yes [ ] No | Are you currently breastfeeding? |
| [ ] Yes [ ] No | Have you had chemotherapy within the last 2 days? |
| [ ] Yes [ ] No | Has your doctor ever told you that you have kidney problems? |
| [ ] Yes [ ] No | Are you currently on Dialysis? |
| [ ] Yes [ ] No | Do you have diabetes? |
| [ ] Yes [ ] No | Do you have high blood pressure? |

**Subject Information (*to be comleted by study coordinator*):**

Creatinine:       eGFR:

Additional Notes: