|  |  |  |
| --- | --- | --- |
|  | | 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: