

HIGH FIELD 1.5 T MRI  
 OPEN MRI  
 CARDIAC NUCLEAR MEDICINE  
 16-SLICE CT ANGIOGRAPHY  
 DIGITAL GENERAL RADIOGRAPHY  
 DIGITAL MAMMOGRAPHY

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AMERICAN BOARD OF RADIOLOGY CERTIFIED



16- SLICE PET/CT SCAN  
 COMPUTED TOMOGRAPHY  
 ULTRASOUND  
 VASCULAR DOPPLER STUDIES  
 ECHOCARDIOGRAPHY  
 OSTEOPOROSIS DEXA SCAN

MRI PATIENT SCREENING RECORD

NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_

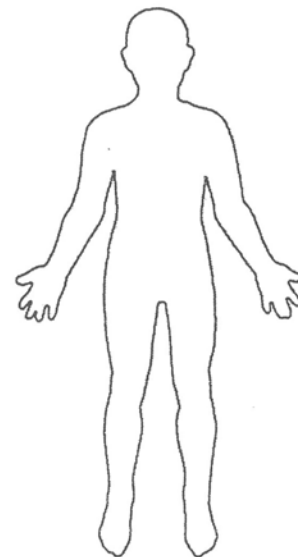
REASON FOR TEST: \_\_\_\_\_

PLEASE CIRCLE THE APPROPRIATE RESPONSE FOR EACH ITEM. (Y=YES N=NO)

1. PACEMAKER Y N
2. PACEMAKER LEADS Y N
3. ARTIFICIAL HEART VALVE Y N
4. PREVIOUS HEART SURGERY Y N
5. BRAIN SURGERY Y N
6. BRAIN ANEURYSM CLIPS Y N
7. DENTURES OR PARTIALS Y N
8. PROSTHESIS (BREAST, LIMB) Y N
9. INNER EAR SURGERY Y N  
(COCHLEAR, STAPES IMPLANT)
10. METAL FRAGMENTS IN EYES Y N
11. EYE LENS IMPLANTS Y N
12. HEARING AIDS Y N
13. INFUSION PUMP Y N
14. IVC UMBRELLA Y N
15. PREGNANT Y N
16. IUD Y N
17. METAL JOINT REPLACEMENT Y N
18. ANY PINS, RODS, OR SCREWS Y N
19. NEUROSTIMULATOR DEVICE Y N
20. SHRAPNEL OR BULLETS Y N

MARK ANY METAL IN YOUR BODY

RIGHT LEFT



PLEASE LIST ANY PREVIOUS SURGERIES AND APPROXIMATE DATES FOR EACH.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I HAVE CAREFULLY REVIEWED AND ANSWERED THE ABOVE QUESTIONS TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
 PATIENT SIGNATURE

\_\_\_\_\_  
 DATE

PLEASE **DO NOT** ENTER THE MRI ROOM WITH A PACEMAKER, BRAIN ANEURYSM CLIPS, OR ANY OF THE FOLLOWING ITEMS:

- |              |              |                     |              |
|--------------|--------------|---------------------|--------------|
| CREDIT CARDS | HEARING AIDS | OXYGEN TANKS        | CHANGE       |
| PURSE/WALLET | WATCHES      | BARRETTES/HAIR PINS | KEYS         |
| JEWELRY      | PAPER CLIPS  | SAFETY PINS         | PENS/PENCILS |