PATIENT MRI SAFETY SCREENING FORM

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MRI procedure. **Do not enter** the MRI room or MRI environment if you have any question or concern regarding an implant, device or object. Consult the MRI Technologist or Radiologist BEFORE entering the room. **The MRI magnet is ALWAYS on.**

Name_____DOB_____ Height_____ Weight_____

Please indicate if you have any of the following:

YES	NO	
☐	☐	Cardiac pacemaker or implanted cardioverter defibrillator/ICD
☐	☐	Aneurysm clip(s) or coil(s)
☐	☐	Neurostimulator-TENS Unit, Biostimulator, bone growth stimulator DBS, VNS
☐	☐	Implanted drug pump (for chemotherapy medicine, pain medicine)
☐	☐	External drug pump (for Insulin or other medicine)
☐	☐	Eye injury from a metal object (metal shavings, metal slivers)
☐	☐	Internal electrodes or wires (pacing wires,DBS or VNS wires)
☐	☐	Artificial heart valve, coil, filter and/or stent (Gianturco coil, IVC filter)
☐	☐	Any type of metal held in by a magnet
☐	☐	Injured by metal object (shrapnel, bullet, BB)
☐	☐	Spinal fixation device, spinal fusion and/or halo vest, spinal cord stimulator
☐	☐	Tissue expander (breast)
☐	☐	Implanted post- surgical hardware (pins, rods, screws, plates, wires)
☐	☐	Artificial joint and/or limb
☐	☐	Artificial eye and/or eyelid spring
☐	☐	Ear (Cochlear) implant, middle ear implant
☐	☐	Hearing aid(s)
☐	☐	IV access port (Port-a-cath, Broviac, PICC line, Swan-Gantz, Thermodilution)
☐	☐	False teeth, dentures, metallic removable dental work, braces, retainers
☐	☐	Medication patch (nitroglyceride, nicotine, contraceptive, estrogen)
☐	☐	Shunt or Sophy adjustable and programmable pressure valve
☐	☐	Surgical clips, staples or surgical mesh
☐	☐	Penile implant or prosthesis
☐	☐	Pessary, IUD, Diaphragm
☐	☐	Radiation seeds (cancer treatment)
☐	☐	Body piercing, tattoo or permanent makeup
☐	☐	Wig, hair implants, bobby pins

If you answered yes to any of the questions above, the technologist will discuss your answers with you.

Do you have a history of:

YES	NO		YES	NO	
☐	☐	Kidney Disease	☐	☐	Latex Allergy
☐	☐	Diabetes	☐	☐	Allergic reaction to MRI contrast (Gadolinium based)
☐	☐	Liver Disease			
☐	☐	History of Cancer _____	☐	☐	Drug Allergy, type_____

Are you on dialysis? ☐ YES ☐ NO

Female Patients:

Are you pregnant? ☐ YES ☐ NO Are you breastfeeding? ☐ YES ☐ NO

If you are still menstruating, please provide the date of your last period_____

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Please describe in detail any symptoms or problems involving the area of your body being scanned today:

_____

_____

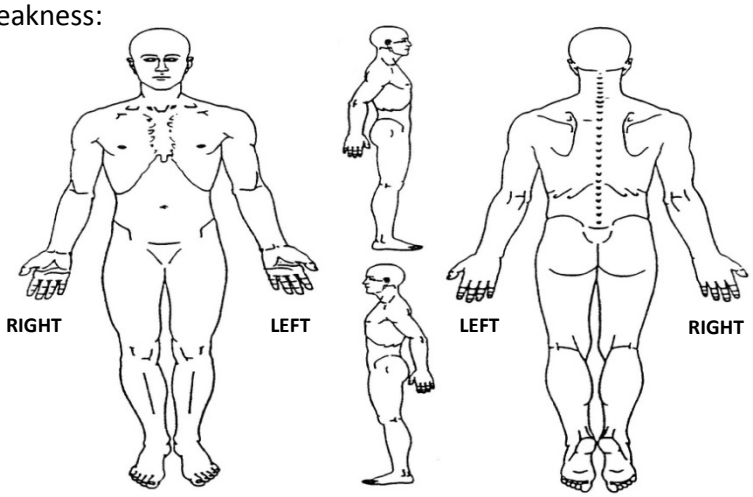
How long have you had your symptoms?_____

Please list any previous surgeries or fractures (including date) involving the area of your body being scanned today:_____

Have you had any previous studies on the same area of your body being scanned today? If so, what type of scan and where was it performed? (ex: MRI/CT/X-ray/ Ultrasound, etc) _____

_____

Please indicate areas of pain, numbness or weakness:



IMPORTANT INSTRUCTIONS

We will provide a locker so **ALL** items you remove may be stored and locked safely during your scan. Please give the key to the technologist **BEFORE** entering the room.

1. Remove all jewelry, body piercing jewelry and all hair accessories.
2. Remove dentures, false teeth, partial dental plates, retainers.
3. Remove hearing aids and eyeglasses.
4. Remove all clothing and change into a hospital gown. Shorts and/or socks will be provided if applicable.
5. Lock your clothes and valuables in the locker provided and remove the key.
6. Please use the restroom before your MRI exam.
7. Please make sure that you receive earplugs and/or headphones before your MRI exam begins. Some patients find the noise levels unacceptable, and the noise levels may affect your hearing.

I attest the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Signature_____ Date_____

Technologist Name/Signature_____