



MRI Safety Screening Form for Patients

(form must be stamped/labeled)

WARNING: MRI is a simple and painless examination. However, because you will be in a strong magnet environment, metal objects in or on your body may be hazardous to yourself or others in the scan room with you. Answering the following questions will provide us with important information BEFORE entering the MRI scan room. The magnet is always on!

NAME: _____ DOB: _____ WEIGHT: _____ Date: ____/____/____

Please answer the following questions:

- 1. Have you had any prior surgery, an operation or an invasive procedure of any kind? Yes No
 If yes, please indicate the date and type of surgery:
 Date ____/____/____ Type of surgery: _____
 Date ____/____/____ Type of surgery: _____
 Date ____/____/____ Type of surgery: _____
- 2. Have you had any GI procedure (eg. Endoscopy/Colonoscopy) within the last 9 months? Yes No
 If yes, please indicate the date: ____/____/____ What facility? _____
- 3. Have you had any prior diagnostic imaging study on the part of the body we're scanning today? Yes No
 If yes, please list: Date Where
 MR _____
 CT/CAT Scan _____
 Ultrasound _____
 Nuclear Med. _____
 Other _____
- 4. Have you experienced any problem related to a previous MRI examination or MR procedure? Yes No
 If yes, please describe: _____
- 5. Have you had an injury to the eye involving a metallic object or fragment (e.g.. Metallic slivers shavings, foreign body, etc) to the eye or other part of the body? Yes No
 If yes, please describe: _____
- 6. Have you ever been injured by a metallic object or foreign body (e.g.. BB, bullet, shrapnel, etc)? Yes No
 If yes, please describe: _____

Sometimes an MRI requires an injection of contrast called gadolinium. It is administered through a small needle which is inserted into a vein in your arm. You may experience the sensation of the contrast being injected, which is normal and expected.

- 7. Are you currently taking or have you recently taken any medication or drug? Yes No
 If yes, please list: _____
- 8. Are you allergic to any medications? Yes No
 If yes, please list: _____
- 9. Do you have a history of asthma, allergic reactions, respiratory disease, or reaction to a contrast media or dye used for an MRI, CT, or X-RAY examination? Yes No
- 10. Do you have anemia or any disease(s) that effects your blood, a history of kidney disease kidney failure, kidney transplant, high blood pressure (hypertension), liver disease or seizures? Yes No
 If yes, please describe: _____
- 11. Do you have a personal history of Cancer? Yes No
 If yes, did you receive chemotherapy or radiation therapy? Yes No

For Female Patients:

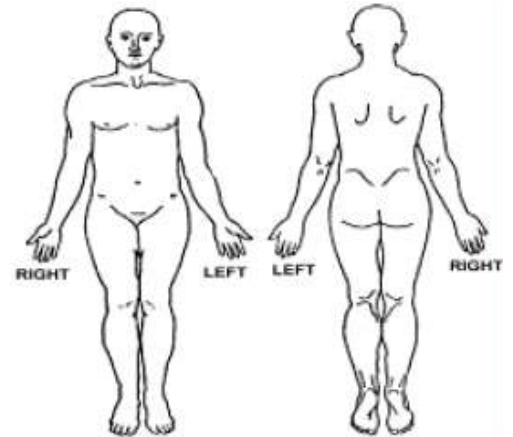
- 12. Date of last menstrual period: ____/____/____ Postmenopausal? Yes No
- 13. Are you pregnant or is there a possibility that you may be pregnant? Yes No
- 14. Are you currently breast feeding? Yes No

Please indicate the symptoms of your current condition and why your doctor sent you for your MRI today _____

Please indicate if you have any of the following:

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cardiac Pacemaker |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted cardioverter defibrillator (ICD) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cochlear, otologic or other ear implants |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aneurysm Clips |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Electronic implant or device |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Magnetically-activated implant or device |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurostimulation system |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Spinal cord stimulator |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Internal electrodes/wires |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Insulin or other infusion pump |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted drug infusion pump |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any type of prosthesis (eye, penile, etc) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart valve prosthesis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eyelid spring or wire |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial or prosthetic limb |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metallic stent, filter or coil |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shunt (spinal or intraventricular) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vascular access port or catheter |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation seeds or implants |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swan-Ganz or thermo dilution catheter |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Medication patch (Nicotine, Nitroglycerine) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any metallic foreign body or fragment |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tissue expander (e.g.. Breast) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgical staple, clips or metallic sutures |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint replacement (hip, knee, etc) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone/joint pin, screw, nail, wire, plate, etc. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | IUD, diaphragm, pessary |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dentures or partial plates |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tattoo or permanent eye makeup |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Body piercing jewelry |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing Aid (remove before entering room) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other implant _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breathing problem or motion disorder |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Claustrophobia |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tracking Anklet/Device |

Please indicate on the figure below the location of any implant or metal inside or on your body



IMPORTANT INSTRUCTIONS

Remove all metallic objects before entering the MR system room. Loose metallic objects are especially prohibited in the MR system room. For this reason, we may have you change into a gown before having your exam. We will provide you with a locker to securely place your belongings.

Please consult the MRI technologist if you have any questions or concerns BEFORE you enter the MR system room.

NOTE: You are required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

Signature of Person Completing Form: _____		Date: ____/____/____
Form Completed By: <input type="checkbox"/> Patient <input type="checkbox"/> Relative <input type="checkbox"/> Nurse _____	Print Name	Relationship to Patient
Form Information Reviewed By: _____	Print Name	Signature

For technologist only

Type of contrast injected: _____ Dose: _____ Route: _____ Date/Time of Injection: _____
 Reaction? _____ Was this an existing IV? Yes No If no, name of person starting IV _____