CHA Cambridge Health Alliance

MRI Safety Screening

Age _____ Weight _____ Height _____

Health questions:

❑ Yes ❑ No Are you claustrophobic?
❑ Yes ❑ No Have you ever had cancer?
If so, any Chemotherapy? ❑ Yes ❑ No Radiation therapy? ❑ Yes ❑ No
❑ Yes ❑ No Have you had any surgery before? Please list **all** surgeries:
Surgery:_____ Left ❑ Right ❑ N/A ❑ Date:_____
Surgery:_____ Left ❑ Right ❑ N/A ❑ Date:_____
Surgery:_____ Left ❑ Right ❑ N/A ❑ Date:_____

Before entering the MR scan room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, glasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, magnetic strip cards, coins, pens, pocket knife, nail clipper tools, clothing with metal fasteners & clothing with metallic threads.

Please consult MRI staff if you have any questions or concerns BEFORE entering the MRI system room.

Do you have any of the following:

❑ Yes ❑ No Pacemaker, defibrillator, or wires
❑ Yes ❑ No Implanted pump, electrode, wire, stimulator
❑ Yes ❑ No Bullet, pellet, BB, shrapnel or metal slivers
❑ Yes ❑ No Radiation seeds or implants in your body
❑ Yes ❑ No Aneurysm clips
❑ Yes ❑ No Possible metal in the eyes
❑ Yes ❑ No Eye, ear, or cochlear implant
❑ Yes ❑ No Heart, eye, or penile prosthesis
❑ Yes ❑ No Staples, clips, or sutures
❑ Yes ❑ No Tissue expanders
❑ Yes ❑ No Stent, coil or filter
❑ Yes ❑ No Epidural, Swan Ganz catheter, or port
❑ Yes ❑ No Ankle bracelet or tracking device
❑ Yes ❑ No Eyelid springs or wire
❑ Yes ❑ No Tattoo, permanent eye makeup, or body piercing
❑ Yes ❑ No Medication patch
❑ Yes ❑ No Shunt
❑ Yes ❑ No Artificial limb
❑ Yes ❑ No Screws, plates, joint replacements
❑ Yes ❑ No Continuous Glucose Monitor
❑ Yes ❑ No Hearing aid or dentures
❑ Yes ❑ No Other (Implant or device-not listed)
_____

Health questions:

❑ Yes ❑ No Do you have any allergies?
❑ Yes ❑ No Do you have diabetes?
❑ Yes ❑ No Do you have any problems with your kidneys?
❑ Yes ❑ No Do you have any allergies to contrast?
❑ Yes ❑ No Have you had kidney surgery, do you have only 1 kidney?

For women:

❑ Yes ❑ No Is there any possibility you may be pregnant? Date of last menstrual period ___/___/___
❑Post-menopausal

❑ Yes ❑ No Are you breastfeeding? (The test and the dye will not hurt your baby).
❑ Yes ❑ No Do you have an IUD, diaphragm, or pessary in place?

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of person completing form_____Date _____ / _____ / _____

Form completed by: ❑Patient ❑Relative ❑RN/MD Print name._____

Reviewed by (MRI staff only): (sign)_____

MRI Staff: (print) _____(Date)_____/_____/_____

Interpreter ID:_____

RN Only:

Monitoring/MR equipment required? ❑ Yes ❑ No