MRI SCREENING AND SAFETY FORM

Fill out this form completely. MRI uses a very strong magnet. Metal objects in your body may be hazardous. Metal objects on your body or clothing may be hazardous to you and others in the MRI scan room. You must remove all loose or removable objects containing metal, before entering the MRI scan room.
What problem or symptoms is this test evaluating? ____

Please indicate if you have had any of the following:

Yes No
- □ □ Brain aneurysm clip(s) or coils
- □ □ Heart valve prosthesis
- □ □ Cardiac pacemaker or defibrillator (or their wires)
- □ □ Internal or external electrodes or wires
- □ □ Neurostimulator, TENS unit, or spinal stimulator
- □ □ Bone growth/bone fusion stimulator
- □ □ Insulin or other infusion pump
- □ □ Medication patch (nicotine, nitroglycerine, etc.)
- □ □ Surgical staples, clips or metal sutures
- □ □ Magnetically-activated implant or device
- □ □ Cochlear implant or other ear implant
- □ □ Hearing aid (remove before entering MRI room)
- □ □ Eye or eyelid implant or metal
- □ □ Any type of prosthesis (eye, penile, etc.)

Yes No
- □ □ Metallic stent, filter, coil, etc.
- □ □ Shunt (spinal or intraventricular)
- □ □ Vascular access port or catheter
- □ □ Swan-Ganz or thermodilution catheter
- □ □ Artificial or prosthetic limb
- □ □ Joint replacement (hip, knee, etc.)
- □ □ Bone pin, screw, nail, wire, plate, etc.
- □ □ Radiation seeds or implants
- □ □ Wire mesh implant or tissue expander
- □ □ IUD, diaphragm or pessary
- □ □ Dentures or partial plates
- □ □ Tattoo or permanent makeup
- □ □ Body piercing jewelry
- □ □ Wound dressing containing silver

- □ □ Have you ever had an eye injury involving a metallic object or fragment (metal sliver, shaving, etc.)?
- □ □ Have you ever been injured by a metallic object (bullet, BB, shrapnel, buckshot, etc.)?
- □ □ Any other metal in your body, list: ____
- □ □ Any other surgical implant, list: ____

(If you have a medical card with surgical implant name/model, please show this to the MRI technologist)

Yes No
- □ □ Are you claustrophobic?
- □ □ Have had any problem related to a previous MRI procedure? ____________________
- □ □ Do you have a history of kidney disease, liver transplant, liver failure, hypertension or diabetes? ____________
- □ □ Do you receive dialysis? If so, when is next dialysis scheduled? ____________________
- □ □ Do you have a history of asthma, allergic reaction, respiratory disease or history of reaction to contrast medium (dye) used for an MRI, CT or x-ray examination?

Female patients: Date of last menstrual period: ____________________

Yes No
- □ □ Are you pregnant?
- □ □ Receiving fertility medication or treatments?
- □ □ On oral contraceptives or hormonal treatment?

Yes No
- □ □ Are you breastfeeding?
- □ □ Postmenopausal?
- □ □ Experiencing a late menstrual period?

****DO NOT ENTER MRI SCAN ROOM IF YOU HAVE ANY UNANSWERED QUESTIONS OR CONCERNS**

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form, have had an opportunity to ask questions about the information on this form and the MRI procedure I am about to undergo, and had all my questions answered.

Patient Signature: ______________________________ Date: ______________
Form completed by: □ Patient □ Other, print name (and title or relationship to patient): ______________

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Place Patient Sticker Here