

Name (first,middle,last):	
Date:	
Date of Birth:	MRN:
Height:	Weight:

MAGNETIC RESONANCE IMAGING (MRI) SAFETY SCREENING FORM

The MRI scan room contains a strong magnetic field that may be hazardous to individuals entering the MRI scan room.

All individuals are required to fill out this safety form **BEFORE** entering the MRI scan room.
Be advised, the MRI magnet is **ALWAYS ON**.

1. Have you had a reaction to MRI contrast? Yes No

If yes, please describe _____

2. Are you diabetic? Yes No

If yes, list any medications you are taking _____ Glucose Monitor? _____

3. Have you had prior surgery or an operation of any kind in the past **8 weeks**? Yes No

If yes, please indicate date and type of surgery. Date: ___/___/___ Type of surgery: _____

4. Have you had an injury to the eye or body involving a metallic object (foreign body, BB, bullet)? Yes No

If yes, please describe: _____

5. Have you ever had a seizure? Yes No

If yes, when? _____ Seizure Medication? _____

6. Are you on Dialysis? (e.g. peritoneal or hemodialysis) Yes No

If yes, when is your next dialysis treatment? _____ Have you been diagnosed with NSF? _____

7. Are you pregnant or suspect that you are pregnant? Yes No



WARNING: Certain implants, devices, or objects may be hazardous to you in the MR scan room
Do not enter the MRI scan room if you have any questions or concerns regarding an implant, device, or object.

Please indicate if you have any of the following: Provide a "yes" or "no" answer for every item.

<input type="checkbox"/> Yes <input type="checkbox"/> No	Deep Brain Stimulator (DBS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Aid
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac Pacemaker, Wires or Defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glucose Monitor
<input type="checkbox"/> Yes <input type="checkbox"/> No	Coils, Stents, Filters, Grafts, Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Limb
<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurostimulator (Spinal Cord or Bone Stimulator)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Implanted Birth Control
<input type="checkbox"/> Yes <input type="checkbox"/> No	Shunt (Programmable or Non-Programmable)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication Patches
<input type="checkbox"/> Yes <input type="checkbox"/> No	Aneurysm Clip(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claustrophobic
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac Occluders	<p>IMPORTANT INSTRUCTIONS</p> <p>If you have any implants (port, aneurysm clip, coils, stents, etc.) and you have an ID card, please let the technologist know.</p> <p>All implants are reviewed for their MRI safety prior to entering the MRI scan room. Please note: if the implant information is not available, the exam may be rescheduled.</p> <p>If prescribed anti-anxiety medication prior to your MRI scan, you must have a driver present or the test may be rescheduled.</p>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin or Other Infusion Pump (Baclofen, Chemo, Pain)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye or Ear Implant (e.g., artificial eye, eyelid spring, cochlear)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Penile Implant		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Halo Vest or Cervical Fixation Device		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Body Piercings, Tattoos, Magnetic Nail Polish or Eyelashes		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast Tissue Expanders, Biopsy Needles or Markers		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Ports or Catheters (e.g., P-Port/Mediport, PICC line, Hickman)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Implanted Devices (e.g. pins, screws, rods, plates, wires)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Recently Ingested A "Pill Camera"		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgical Clips, Staples, Mesh, Vascular Clips/Clamps		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Removable Dental Work (e.g. partial plates)		

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

Patient/Parent/Guardian/Other Signature: _____

Date: _____

MRI Technologist Signature: _____

Date: _____