



### MRI SCREENING FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_

**Medical History:** Please indicate if you have any of the following.

		Yes	No
1	<b>Cardiac Pacemaker or Implanted Cardiac Defibrillator (ICD)</b>	<input type="checkbox"/>	<input type="checkbox"/>
2	<b>Internal Electrodes or Wires</b> (pacing wires, DSA or VNS wires)	<input type="checkbox"/>	<input type="checkbox"/>
3	Artificial Heart Valve(s) *Mechanical*	<input type="checkbox"/>	<input type="checkbox"/>
4	<b>Ear (Cochlear) Implant</b> , middle ear implant, otologic implant	<input type="checkbox"/>	<input type="checkbox"/>
5	<b>Neurostimulator-</b> bladder, spinal cord, TENS unit, bone growth, other	<input type="checkbox"/>	<input type="checkbox"/>
6	Any <b>Medication Pump</b> or infusion device. (Internal or External)	<input type="checkbox"/>	<input type="checkbox"/>
7	<b>Shunt</b> or programmable pressure valve. (Spinal, Ventricular, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
8	<b>Aneurysm Clips</b> , cerebral clip, brain clip, carotid artery clamp.	<input type="checkbox"/>	<input type="checkbox"/>
9	Mechanical tissue expander (breast, post-mastectomy)	<input type="checkbox"/>	<input type="checkbox"/>

If answering "YES" to any question above, special care is needed to maintain your comfort and safety. **Please discuss with your MRI technologist prior to having MRI.**

10	Artificial Heart Valve (tissue) , Stents, filter or coil (Gianturco Coil, IVC filter, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
11	Insulin pump, glucose monitor, etc. <b>(MUST BE REMOVED PRIOR TO MRI)</b>	<input type="checkbox"/>	<input type="checkbox"/>
12	Eye injury involving metal fragments (metal shaving, metal slivers) Injury from foreign metal object. (Shrapnel, bullet, BB) Location: _____	<input type="checkbox"/>	<input type="checkbox"/>
13	Artificial eye or other <b>eye surgeries.</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
14	Spinal Surgery, spinal fusion. When? _____	<input type="checkbox"/>	<input type="checkbox"/>
15	Implanted post-surgical hardware: pins, screws, plates, rods, wires	<input type="checkbox"/>	<input type="checkbox"/>
16	Artificial joint and/ or limb - including <b>total joint replacements</b>	<input type="checkbox"/>	<input type="checkbox"/>
17	Surgical clips, staples and or surgical mesh. Location: _____	<input type="checkbox"/>	<input type="checkbox"/>
18	IV access port (Port-a-Cath, PICC line, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
19	Medication patch (pain med, estrogen, nicotine, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
20	IUD, Pessary, Diaphragm	<input type="checkbox"/>	<input type="checkbox"/>
21	Dental work: dentures, braces bridge, post-implant, retainers etc.	<input type="checkbox"/>	<input type="checkbox"/>
22	Hearing Aids <b>(MUST BE REMOVED PRIOR TO MRI)</b>	<input type="checkbox"/>	<input type="checkbox"/>



		Yes	No
23	Wig, hairpiece, hairpins, hair extensions	<input type="checkbox"/>	<input type="checkbox"/>
24	Body piercings, tattoos, permanent makeup ( <b>Please Remove Piercings</b> )	<input type="checkbox"/>	<input type="checkbox"/>
25	<b>Other implants not previously listed:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
26	Claustrophobic or motion disorder	<input type="checkbox"/>	<input type="checkbox"/>
27	Any prior imaging studies or surgeries pertaining to today's study:	<input type="checkbox"/>	<input type="checkbox"/>
28	Any known allergies: _____	<input type="checkbox"/>	<input type="checkbox"/>

**IMPORTANT INSTRUCTIONS**

Before entering the MR environment or MR system room, you must **remove ALL metallic objects** including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clippers, tools, clothing with metal fasteners, and clothing with metallic threads.

*MRI is usually avoided during the first trimester of pregnancy.*

If you have a pacemaker, neurostimulator, aneurysm clips, hearing aids, insulin pump, inner ear implants, **PLEASE STOP NOW** and inform the Radiology personnel immediately.

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

**NOTE:** You may be advised or required to wear earplugs or other hearing protection during the MRI procedure to prevent possible problems or hazards related to acoustic noise.

**CONTRAST AGENT INFORMATION**

As part of the MRI examination, if your referring physician and the radiologist deem it advisable, you may be given an intravenous injection of gadolinium, a contrast agent used in MRI. This injection increases the accuracy of the scan to better diagnose your condition. Gadolinium contrast agents have been used safely in millions of cases, but minor reactions (headaches, nausea, or itchiness) occur in about 2% of patients and rare life-threatening reactions have been reported. *Breastfeeding mothers: There is a very small percentage of contrasted material that is excreted into the breast milk and absorbed by the infant. Available data suggest it is safe to continue breastfeeding. However if you are concerned, you may abstain from breastfeeding for 12 to 24 hours (express and discard breast milk).*

**Initials:**

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 MRI procedure that I am about to undergo.

\_\_\_\_\_  
Signature of person completing form

\_\_\_\_\_  
Print name

Date \_\_\_\_\_

\_\_\_\_\_  
Relationship to patient