



Name: _____ Date of Birth: _____

Patient Height: _____ Patient Weight: _____

Patient Identification

ATTENTION MRI PATIENTS AND FAMILY MEMBERS: The MRI room contains a very strong magnet and it is **ALWAYS** on. Before you are allowed to enter the MRI room, we **MUST** know if you have any metal in or on your body because some metal objects can interfere with your scan or even be dangerous projectiles. You **MUST** remove all metallic objects including hearing aids, keys, pagers, cell phones, watches, hair barrettes, pocket knives, lighters, bank cards, purses, wallets electronic monitoring bracelets, and jewelry. Please answer the following questions **carefully**.

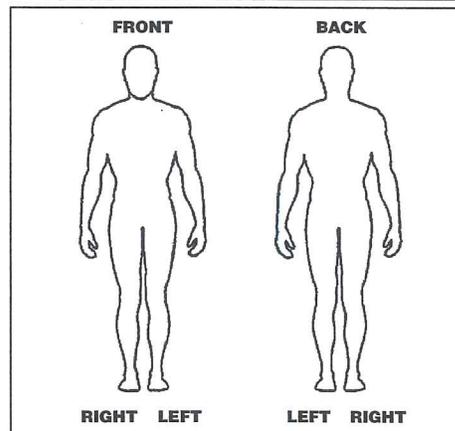
Please Circle Yes or No:

- 1. Yes No Have you had an MRI before? When? _____ Where? _____
- 2. Yes No Have you ever had a reaction or complication from an injection of contrast dye?
If **YES**, when and what was the reaction? _____
- 3. Yes No Do you have a medication or latex allergy? If so, please specify: _____
- 4. Yes No Do you have kidney disease, kidney failure, transplanted kidney, single kidney, a family history of polycystic kidney disease, NSF (Nephrogenic Systemic Fibrosis), or have you had any other kidney surgery?
- 5. Yes No Are you currently undergoing dialysis?
- 6. Yes No Do you have diabetes, congestive heart failure, hypertension, liver disease or Sickle Cell disease?

Do You Have Any of the Following?

- 7. Yes No Aneurysm clip or coil?
- 8. Yes No IntraCranial pressure (ICP) monitoring catheter?
- 9. Yes No Cardiac pacemaker or Implantable Cardioverter Defibrillator (ICD), internal electrodes or pacing wires?
- 10. Yes No Heart valve, Cardiac Stent, IVC filter, or any other intravascular devices? Type? _____ Date? _____
- 11. Yes No Temperature sensing Foley catheter?
- 12. Yes No Electrical stimulator for nerves or bones (DBS, VNS)?
- 13. Yes No A history of metal shavings, slivers, eyelid spring, wire, or gold eyelid weight or specks of metal in your eye?
- 14. Yes No Dentures or partial plate?
- 15. Yes No Cochlear implant, other ear implant or hearing aid? (Hearing aids must be removed prior to entering scanner room.)
- 16. Yes No Intravascular device such as stent, filter, shunt or coil? If so, Type? _____
Location? _____ Date of Implantation? _____
- 17. Yes No Vascular access port and/or catheter?
- 18. Yes No Swan-Ganz or thermodilution catheter?
- 19. Yes No Insulin or drug infusion pump? Type: _____
- 20. Yes No Any type of Orthopedic hardware? (joint replacement, plates, screws, wires, pins, nails, etc.)
- 21. Yes No Any type of electronic, mechanical or magnetic implant or prosthesis (eye, penile, prosthetic limb, etc.)?
- 22. Yes No Tissue expander (e.g. breast)?
- 23. Yes No Radiation seeds or implants?
- 24. Yes No Any metallic objects in your body (bullets, bb's, shrapnel, surgical staples, clips, metallic sutures, electrodes, pins, screws, plates, wires or wire mesh)?
- 25. Yes No Have you had previous spinal surgery? At what level? _____
- 26. Yes No Tattoo, permanent makeup or body piercing jewelry?
- 27. Yes No EKG patch, wound dressing or medication patch (e.g. Acticoat, nicotine, nitroglycerine, pain, hormone, etc)?
- 28. Yes No Have you ever ingested a PillCam video capsule? Date ingested: _____

Using the diagram below, please indicate the location of your pain with a circle (O) **AND** any implant or metal in your body with an arrow (→).



This list is not inclusive. Please indicate other surgical implants not mentioned on this safety screening form:

- 29. Yes No Do you have a history of any type of cancer? _____ What type and treatment? _____
- 30. Yes No Are you or could you be pregnant or are you breastfeeding? _____ Date of last menstrual cycle? _____
- 31. Yes No IUD or diaphragm?

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

Signature (Patient or Guardian): _____ Date: _____ Time: _____

Protocol changed to _____ per Dr. _____ Date: _____ Time: _____

I have reviewed this form and confirmed that all hazardous removable electronic and metallic items have been detached from the patient.

Signature of Technologist: _____ Date: _____ Time: _____

