MAGNETIC RESONANCE (MR) SAFETY AND SCREENING FORM FOR PATIENTS

To be completed by the patient and reviewed by the provider

Patient Name:	**DOB:**
Height/Weight:	**Exam Date:**

Warning: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. Do not enter the MR area if you have any question or concern regarding an implant, device, or metal object. Consult the MR Technologist BEFORE entering the MR room.

For female patients: Are you or Is there a chance you may be pregnant?	☐ Yes	☐ No
Did your provider prescribe something for anxiety, nerves, pain or claustrophobia for the day of the MRI procedure?	☐ Yes	☐ No
**If yes, please list:		
(To be filled by MRI Tech): Has patient taken something for anxiety, nerves, pain or claustrophobia today?	☐ Yes	☐ No

Please indicate if you have any of the following:

Aneurysm clip	☐ Yes	☐ No	Swan-Ganz or thermodilution catheter	☐ Yes	☐ No
Cardiac pacemaker	☐ Yes	☐ No	Medication patch (Nicotine, Nitroglycerine, etc)	☐ Yes	☐ No
Implanted cardioverter defibrillator (ICD)	☐ Yes	☐ No	Any metallic fragment or foreign body	☐ Yes	☐ No
Electronic implant or device	☐ Yes	☐ No	Surgical staples, clips, or metallic sutures	☐ Yes	☐ No
Magnetically-activated implant or device	☐ Yes	☐ No	Joint replacement (hip, knee, ect)	☐ Yes	☐ No
Cochlear, otologic or other ear implant	☐ Yes	☐ No	Bone/joint/spine pin, screw, nail, wire, plate, etc	☐ Yes	☐ No
Implanted drug infusion device	☐ Yes	☐ No	Halo vest	☐ Yes	☐ No
Wire mesh implant	☐ Yes	☐ No	Neurostimulation system	☐ Yes	☐ No
Other implant:_____	☐ Yes	☐ No	Spinal cord stimulator	☐ Yes	☐ No
Radiation seeds or implants	☐ Yes	☐ No	Internal electrodes or wires	☐ Yes	☐ No
Breast biopsy needle in place	☐ Yes	☐ No	Bone growth/bone fusion stimulator	☐ Yes	☐ No
Tracheotomy tube	☐ Yes	☐ No	IUD, diaphragm, or pessary	☐ Yes	☐ No
Insulin or other infusion pump	☐ Yes	☐ No	Eyelid spring or wire	☐ Yes	☐ No
Artificial or prosthetic limb	☐ Yes	☐ No	Metallic stent, filter, or coil	☐ Yes	☐ No
Any type of prosthesis (eye, penile, etc)	☐ Yes	☐ No	Shunt (spinal or intraventricular)	☐ Yes	☐ No
Heart valve prosthesis	☐ Yes	☐ No	Vascular access port and/or catheter	☐ Yes	☐ No
Dentures or partial plates	☐ Yes	☐ No	Tissue expander (e.g. breast)	☐ Yes	☐ No
Dental braces or retainer	☐ Yes	☐ No	Tattoo or permanent makeup	☐ Yes	☐ No
Hair implants, wig	☐ Yes	☐ No	Body piercing jewelry	☐ Yes	☐ No

Important Questions			
Have you ever had an injury from a metal object in your eye (metal slivers, metal shavings, or other metal object)?		☐ Yes	☐ No
If yes, did you see a physician?		☐ Yes	☐ No
Did the physician tell you that the object was completely removed from your eye?		☐ Yes	☐ No
Have you ever been injured by a metal object or foreign body (e.g. bullet, BB, shrapnel)?		☐ Yes	☐ No
If yes, please describe:			
Have you ever had a surgical operation or procedure of any kind?		☐ Yes	☐ No
If yes, list all prior surgeries and approximate dates:			
Date:	Procedure:		
Have you ever had an endoscopy or colonoscopy?		☐ Yes	☐ No
If yes, list the procedure and approximate dates:			
Date:	Procedure:		

I attest that the information provided on both pages of this form are correct to the best of my knowledge.

Patient's Name (Print): _____

Patient's Signature: _____ **Date:** _____

Information Reviewed by: _____ **Date:** _____

Only complete the below when returning for a second visit within 30 days. After 30 days, new paperwork must be completed.

I attest that the information provided on both pages of this form are still correct to the best of my knowledge.

Patient's Signature: _____ **Date:** _____

Information Reviewed by: _____ **Date:** _____