MRI SCREENING FORM

First Name: _____ M.I. _____ Last Name: _____

DOB: _____ M/ F Height: _____ Weight: _____lbs Physician: _____

Address: _____Cell: _____

Describe your symptoms? _____How often: _____

List Surgeries: _____

List prior imaging studies that pertain to this problem: _____

Have you ever had a reaction to MRI contrast/dye? _____

List any allergies: _____ Email: _____

WARNING: **Certain implants, devices, or objects may be hazardous to your safety** and may interfere with the MRI. **DO NOT ENTER** the MRI room if you have any question or concern regarding an implant, device or object until consulting with the MRI Technologist. **The MRI magnet is ALWAYS on**. The information requested below is very important. Please answer all questions as thoroughly as possible.

Please indicate yes or no if you have any of the following:

O No O Yes **Aneurysm clip(s)**	O No O Yes PICC line, port, catheter
O No O Yes **Cardiac Pacemaker**	O No O Yes Shunt, Stent, Intravascular Coil
O No O Yes Implant cardioverter defibrillator (ICD)	O No O Yes Radiation seeds or implants
O No O Yes Electronic implant or device	O No O Yes Metal in eyes/Injury to eyes (metallic slivers, shavings)
O No O Yes Magnetically-activated implant or device	O No O Yes Metal removed from eye(s)
O No O Yes Tens Unit/Neurostimulator/Biostimulator	O No O Yes Injury by a metallic fragment (bullet, BB, shrapnel)
O No O Yes Spinal cord stimulator	O No O Yes Wire mesh implants
O No O Yes Tissue expander (e.g. breast)	O No O Yes Internal electrodes or wires
O No O Yes Surgical staples, clips or metallic sutures	O No O Yes Bone growth/Bone fusion stimulator
O No O Yes Bone/joint pin, screw, nail, wire, plate, rod	O No O Yes IUD, diaphragm, pessary
O No O Yes Insulin, pain or other infusion pump	O No O Yes Dentures/partial/retainer
O No O Yes Any patch (medication, pain, nicotine, nitroglycerin)	O No O Yes Tattoo/permanent makeup/body piercing
O No O Yes Any type of prosthesis or implant (eye, penile)	O No O Yes Eyelid spring or wire
O No O Yes Artificial or prosthetic limb	O No O Yes **Hearing aid (remove before entering MRI room)**
O No O Yes Heart valve prosthesis	O No O Yes **Cochlear, otologic, or other ear implant**
O No O Yes **Acute renal insufficiency due to hepato-renal syndrome**	O No O Yes In perioperative liver transplant period
O No O Yes **Acute or chronic renal disease**	O No O Yes Any prior transplants (liver/kidney/other)
O No O Yes **Dialysis**	O No O Yes Hepatic (liver) Disease
O No O Yes **Diabetes**	
O No O Yes Blood-related disorder (Anemia, Leukemia, Sickle Cell) If answered "Yes" to Anemia, have you received an injection of **Ferumoxytol**	O No O Yes If Yes, when _____
O No O Yes Multiple Sclerosis	O No O Yes Breathing problems or motion disorder
O No O Yes Hypertension (high blood pressure)	O No O Yes Seizures
O No O Yes Cancer If yes, where _____	O No O Yes Have you taken oral sedating medication for this MRI?
O No O Yes Back or Neck Surgery	O No O Yes Joint replacement (hip, knee, shoulder)
O No O Yes Currently Breast Feeding	O No O Yes O Maybe **Pregnant**

WARNING: **Before entering the MRI room, YOU MUST REMOVE ALL metallic objects** including, but not limited to, the following: hearing aids, dentures, partial plates, keys, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercings, watch, safety pins, money clip, credit/bank/magnetic strip cards, coins, pens, pocket knife, handgun, nail clippers, tools, clothing with metal fasteners or metallic threads. You will be asked to wear MRI safe earplugs or headphones during the exam**.**

CONSENT: I have informed the technologist that **I do not have any metallic devices** such as a pacemaker, implant, cerebral aneurysm clips in my body or metallic foreign bodies in my eyes. I further affirm the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions. I have also informed the technologist that **I am not pregnant at this time.**

Signature of Person Completing Form: _____ Date: _____

Relationship to Patient: □ Self □ Spouse □ Guardian

Technologist who reviewed safety screening with patient: _____ Date: _____

(Print first and last name)