MRI EXAM and METAL PRE-SCREENING FORM

Name ____ DOB _______ Weight _______ Height _______Date _______

MRI uses a very powerful magnet, which can disturb certain metallic objects or implants in the body. To insure your safety, we ask that you very carefully complete the following screening questions. If you have any questions, or need assistance completing this form, please see an MRI Staff Member.

YES NO **Please mark Yes or No to indicate if you have any of the following:**

* ☐ ☐ Have you EVER sought medical treatment due to an object that may have been metal striking the eye(s)
  (Example: from grinding, welding, drilling, shrapnel, etc.)
  *If yes, please specify if object was removed or if your eye exam, by a physician, was negative.
  Removed ________ Negative Exam________ Not removed/ Unknown ________
- ☐ ☐ Ever had a Cardiac Pacemaker or Pacer Wires? __Still Implanted __ All Removed __ Wires Remain
- ☐ ☐ Aneurysm Surgery(s): If YES where? ____
- ☐ ☐ Vagal Nerve Stimulator (Brain Pacemaker)
- ☐ ☐ Biostimulator, Neurostimulator (TENS unit), Bone Stimulator?__Still Implanted__All Removed __Wires Remain
- ☐ ☐ Are you Claustrophobic or are you bothered by small places?
- ☐ ☐ Implanted Medication or Insulin Pump
- ☐ ☐ Medication Patches such as Nitroglycerin,Pain, birth control, or nicotine (these items must be removed)
- ☐ ☐ Heart Valves, Shunt, Programable Valve or Shunt, Coils, Filters, Stent, Zenith Graft for Abd Aortic Aneurysm
- ☐ ☐ Any implanted Metal Rods, Plates, Pins, Screws, Nails, Wire Mesh, or Clips from surgery
- ☐ ☐ Artificial Joint or Limb Replacement
- ☐ ☐ Shrapnel, Buckshot, Bullets, or BB's still in your body
- ☐ ☐ Eye Surgery or Artificial Eye Implant
- ☐ ☐ Ear Surgery or Ear Implant (Cochlear or Stapes Implant)
- ☐ ☐ Hearing Aid
- ☐ ☐ Dentures, Braces or any Removable Dental Ware
- ☐ ☐ Bravo or M2A procedure in last 30 days (small camera that was swallowed to monitor digestion)
- ☐ ☐ Any Hair pins/clips, Wigs, Hair pieces, Extensions
- ☐ ☐ Any type of Electrical, Mechanical, or Magnetically-activated implant not mentioned**,** Please list_________________
- ☐ ☐ Magnetic Eyelashes, Permanent Eyeliner*, Tattoos*, or Body Piercing *[*A SMALL PERCENTAGE OF PATIENTS WITH TATTOOS HAVE EXPERIENCED TRANSIENT SKIN IRRITATION IN ASSOCIATION WITH MRI. THEREFORE YOU MAY WANT TO DECIDE IF THIS SLIGHT RISK WARRANTS UNDERGOING YOUR EXAMINATION AND DISCUSS THIS WITH YOUR REFERRING PHYSICIAN].*
- ☐ ☐ Do you have a history of (current or previous) ANY of the following: Renal (Kidney) Disease or Insufficiency; Kidney Transplant; Solitary Kidney, Renal Tumor, Liver Transplant or Pending Liver Transplant; Hepato-Renal Syndrome?
- ☐ ☐ Do you have Diabetes? If yes, ____ Type 1 _____Type 2 Do you have a Diabetic Blood Draw Port?________
- ☐ ☐ Do you have High Blood Pressure (Hypertension)?
- ☐ ☐ Have you had any blood work the past 6 weeks? If so, Lab Date: ______ Location____________________________
- ☐ ☐ Do you have an allergy to contrast? What test was being done when you had the reaction? ____________________

- ☐ ☐ **MALE PATIENTS ONLY:** Do you have a Prostate Stent or a Penile Implant?
- ☐ ☐ **FEMALE PATIENT ONLY:** Are you pregnant or do you suspect that you are pregnant?
- ☐ ☐ **FEMALE PATIENT ONLY:** Do you have an IUD, Diaphragm or Pessary?
- ☐ ☐ **FEMALE PATIENT ONLY:** Do you have a Breast Tissue Expander?
- ☐ ☐ **FOR INPATIENTS ONLY:** Swan-Ganz Catheter
- ☐ ☐ **FOR INPATIENTS ONLY:** Temperature Probe

I have answered these questions to the best of my ability and I understand that possible injury could be a result of my withholding vital information.

Signature of Patient/Guardian ____ Date ______________

For Office use Only

MD/RT/RN/Coordinator signature preliminary screening patient: ____

FORM MUST BE SIGNED BY A TECH or NURSE BEFORE PATIENT CAN ENTER THE SCAN ROOM

Signature of Staff Member Approving Patient entry into scanner: ____

Name of scanning Technologist: ____