MRI Safety Screening Form

Complete the following: (completed by radiology associate)	
Date:	☐ Refer to MRI Exam Form for the following
Patient Name:______________	**Weight -**
Date of Birth:______________	**Reason for exam:**
Medical Provider	

NOTE: Your medical provider has requested a MRI examination. MRI has a **strong magnet** and radio frequencies. No long term effects have been identified, however **serious injury may occur** when entering the MRI scan room **if your information is inaccurate and incomplete.**

Answer "yes" or "no" for each question.	**Yes**	**No**	**Answer "yes" or "no" for each question.**	**Yes**	**No**
Brain aneurysm clip			Radiation seeds (e.g. cancer treatment)		
Presently or suspect pregnancy			Any type of coil, filter, stent		
Pacemaker (have you ever had)			Any type of implant held in place by a magnet		
Implantable cardiac defibrillator			Surgical mesh		
Artificial heart valve			Tissue expander (e.g., breast)		
Biostimulator			Any type of surgical clip or staple		
Any type of internal electrodes/wires			Artificial Limb or joint		
Any type of electronic, mechanical or magnetic implant			Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, PICC line)		
Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain)			Any implanted items (e.g., pins, rods, screws, nails, plates, wires)		
Shunt			History of claustrophobia		
Neurostimulator			Medication patch (e.g., nitroglycerin, nicotine)		
Halo vest			Penile implant		
Spinal fixation device			Tattoos, or tattooed makeup		
Spinal fusion procedure			Jewelry		
Any type of metal object (e.g., bullet, shrapnel, BB)			Any hair accessories (e.g., bobby pins, barrettes, clips)		
Any type of ear implant			Body piercings		
Hearing aid			Diaphragm, IUD, pessary, Other OB birth control implantable devices		
Artificial eye			Wig, hair implants		
Eyelid spring			Removable dentures, false teeth, partial plate		
Presently breastfeeding			Any other type of implanted item		

If any of the above items were answered "yes", complete. (completed by MR1)

Type	Location	Date implanted

NOTE: The following items may be harmful to you during your MR scan or may interfere with the exam.

CONSIDER THAT ALL METAL ITEMS AND ELECTRONICS NEED TO BE REMOVED

(completed by patient/designee)

Answer the following (completed by patient/designee)	**Yes**	**No**	**N/A**
I have removed all **jewelry** (e.g. watches, necklaces, pins, rings)			
I have removed all **hair pins**, bobby pins, barrettes, clips, etc.			
I have removed all **dentures,** false teeth, partial dental plates.			
I have removed **hearing aids**			
I have removed **eyeglasses**			
I have removed **pager, cell phone,** credit and bank cards and all other cards with magnetic strips.			
I have removed all **body piercings**			
I will **use the ear plugs** or headphones that we supply since some patients may find the noise levels unacceptable, and the noise may affect my hearing.			

Mark on the drawing the location of any metal inside you or site of any surgical operation.

Front

Back

Have you ever had:	**Yes**	**No**		**Yes**	**No**
MRI exam before and had a problem?			Injured by a metal object or foreign body (i.e. bullet, BB, shrapnel?		
An x-ray dye used or MRI contrast agent?			A history of seizures?		
An allergic reaction to either x-ray or MRI contrast?			Surgical operation or procedure of any kind?		
An injury from a metal object in your eye (metal slivers, metal shavings, other metal object)?			A history of allergic respiratory disease?		
A history of kidney disease?			A history of asthma?		

I attest to the best of my knowledge that the above information is correct. I have read and understand the entire contents of this form, and I have had the opportunity to ask questions regarding the information on this form.

Patient/Designee Signature______________________________ Date____________________