The Women's Imaging Center

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MRI Safety Screening Form

Patient Name: ______________________________

Patient Height: ____________ Weight: ____________

Any medication or food allergies: YES NO

If yes please list and describe reaction:

____

____

The following items may be harmful to you during the MRI scan or may interfere with the exam. You must provide a YES or NO for every item. Please explain any YES answers.

YES __ NO __ Cardiac Pacemaker or Defibrillator

YES __ NO __ Aneurysm Clips

YES __ NO __ Neurostimulator

YES __ NO __ Any type of INTERNAL electrodes or wires ________________

YES __ NO __ Ear implants

YES __ NO __ Hearing aids

YES __ NO __ Any surgery on your eyes, ears, vessels of your head, or heart ________________

YES __ NO __ Implanted drug pump (example: Insulin, Baclofen, Chemotherapy, Pain) ____________

YES __ NO __ Any coil, stent, or filter. Type: ____________________

YES __ NO __ Any type of metal object in your body (example: bullet, shrapnel, BBs) Location: ________

YES __ NO __ Any artificial body parts ____________________

YES __ NO __ Any adhesive patches (example: Nicotine, hormone replacement, birth control)

YES __ NO __ Surgical mesh. Location: ____________________

YES __ NO __ Body piercings (other than ears). Location: ____________________

YES __ NO __ Tattoo (including tattooed eyeliner) Location: ____________________

YES __ NO __ Have you ever worked with metal? (example: grinding, welding)

YES __ NO __ Have you ever had metal in, or removed from, your eyes?

OVER →

YES __ NO __ Any other type of implanted items? ________________________________

YES __ NO __ Hair extensions

YES __ NO __ Is there any chance you are pregnant?

Do you have, or have you had, any of the following:

Prior MRI or CT with contrast	YES __ NO __	Approx. date of exam ________
Was there any reaction	YES __ NO __	
If yes please explain ________________________________		
History of anaphylactic reaction	YES __ NO __	
Asthma	YES __ NO __	
Renal problems	YES __ NO __	
If yes, have you had recent blood work?	YES __ NO __	
Diabetes	YES __ NO __	
Sickle cell anemia	YES __ NO __	
Cancer Type: ________________	YES __ NO __	
Are you breast feeding?	YES __ NO __	
Date of your last menstrual cycle ____/____/____		

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

Patient signature: ________________________________ Date: __________

Technologist signature: ____________________________ Date: __________

For technologist use only:

Contrast amt: _________ Contrast agent: ________________ IV location: __________

Any complications with contrast or IV: ______________________________

CREAT: _______ GFR: _______ Date taken: _____________ Dr Office WIC