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?
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
Was there any reaction
If yes please explain ________________________________

YES   NO   Approx. date of exam ________

YES   NO

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