3T MRI
THE PATIENT-FRIENDLY MRI EXPERIENCE

SAFETY SCREENING FORM
FOR MAGNETIC RESONANCE (MR) PROCEDURES

Date: _____

Name (first middle last): _____

☐ Female ☐ Male Age: _____ Date of Birth: _____ Height: _____ Weight: _____

WHY ARE YOU HAVING THIS EXAMINATION (MEDICAL PROBLEM)?

_____

_____

_____

Have you ever had an MRI examination before and had a problem? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever had a surgical operation or procedure of any kind? ☐ Yes ☐ No

If yes, list all prior surgeries and approximate dates: _____

_____

Have you ever been injured by a metal object or foreign body (e.g., bullet, BB shrapnel)? ☐ Yes ☐ No

If yes, please describe: _____

_____

Have you ever had an injury from a metal object in your eye (metal slivers, metal shavings, other metal object)? ☐ Yes ☐ No

If yes, did you seek medical attention? ☐ Yes ☐ No

If yes, describe what was found: _____

Do you have a history of kidney disease, asthma, or other allergic respiratory disease? ☐ Yes ☐ No

Do you have any drug allergies? ☐ Yes ☐ No

If yes, please list drugs: _____

Have you ever received a contrast agent or X-ray dye used for MRI, CT, or other X-ray or study? ☐ Yes ☐ No

Have you ever had an X-ray dye or magnetic resonance imaging (MRI) contrast agent allergic reaction? ☐ Yes ☐ No

If yes, please describe: _____

_____

Are you pregnant or suspect you may be pregnant? ☐ Yes ☐ No

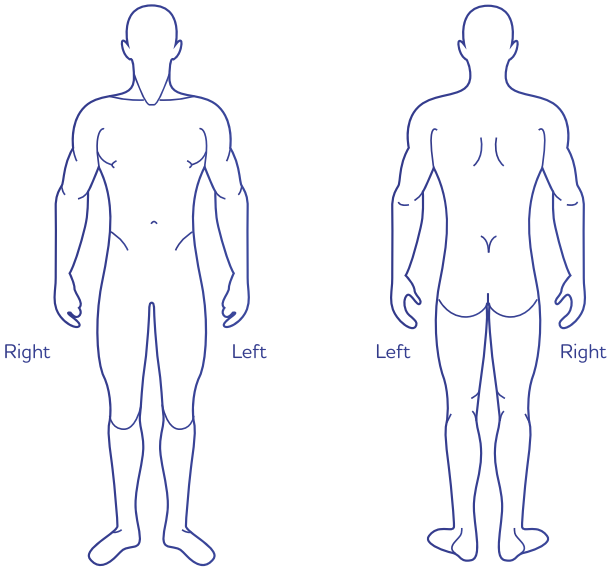
Are you breast feeding? ☐ Yes ☐ No

Date of last menstrual period: _____

Post-menopausal? ☐ Yes ☐ No

MR HAZARD CHECKLIST

Please mark on the drawings provided the location of any metal inside your body or site of surgical operation.



The following items may be harmful to you during your MR scan or may interfere with the MR examination. You must provide a "yes" or "no" for every item. Please indicate if you have or have had any of the following:

- ☐ Yes ☐ No Any type of electronic, mechanical, or magnetic implant - Type: _____
- ☐ Yes ☐ No Cardiac pacemaker
- ☐ Yes ☐ No Aneurysm clip
- ☐ Yes ☐ No Implanted cardiac defibrillator
- ☐ Yes ☐ No Neurostimulator
- ☐ Yes ☐ No Biostimulator - Type: _____
- ☐ Yes ☐ No Any type of internal electrodes or wires
- ☐ Yes ☐ No Cochlear implant
- ☐ Yes ☐ No Hearing aid
- ☐ Yes ☐ No Implanted drug pump (e.g., insulin, Baclofen, chemotherapy, pain medicine)
- ☐ Yes ☐ No Halo vest
- ☐ Yes ☐ No Spinal fixation device
- ☐ Yes ☐ No Spinal fusion procedure
- ☐ Yes ☐ No Any type of coil, filter, or stent - Type: _____
- ☐ Yes ☐ No Any type of metal object (e.g., shrapnel, bullet, BB)
- ☐ Yes ☐ No Artificial heart valve
- ☐ Yes ☐ No Any type of ear implant
- ☐ Yes ☐ No Penile implant
- ☐ Yes ☐ No Artificial eye
- ☐ Yes ☐ No Eyelid spring
- ☐ Yes ☐ No Any type of implant held in place by a magnet - Type: _____
- ☐ Yes ☐ No Any type of surgical clip or staple
- ☐ Yes ☐ No Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, Picc line)
- ☐ Yes ☐ No Medication patch (e.g., Nitroglycerine, nicotine)
- ☐ Yes ☐ No Shunt

☐ Yes	☐ No	Artificial limb or joint - What and Where: _____
☐ Yes	☐ No	Tissue Expander (e.g., breast)
☐ Yes	☐ No	Removable dentures, false teeth or partial plate
☐ Yes	☐ No	Diaphragm, IUD, Pessary - Type: _____
☐ Yes	☐ No	Surgical mesh - Location: _____
☐ Yes	☐ No	Body piercing - Location: _____
☐ Yes	☐ No	Wig, hair implants
☐ Yes	☐ No	Tattoos or tattooed eyeliner
☐ Yes	☐ No	Radiation seeds (e.g., cancer treatment)
☐ Yes	☐ No	Any implanted items (e.g., pins, rods, screws, nails, plates, wires)
☐ Yes	☐ No	Any hair accessories (e.g., bobby pins, barrettes, clips)
☐ Yes	☐ No	Jewelry
☐ Yes	☐ No	Any other type of implanted item - Location & Type: _____

INSTRUCTIONS FOR THE PATIENTS

1. You are urged to use the ear plugs or headphones that we supply for use during your MRI examination because some patients may find the noise levels unacceptable, and the noise levels may affect your hearing.
2. Remove all jewelry (e.g., necklaces, pins, rings).
3. Remove all hair pins, bobby pins, barrettes, clips, etc.
4. Remove all dentures, false teeth, partial dental plates.
5. Remove hearing aids.
6. Remove eyeglasses.
7. Remove your watch, pager, cell phone, credit and bank cards and all other cards with a magnetic strip.
8. Remove body piercing objects.
9. Use gown, if provided, or remove all clothing with metal fasteners, zippers, etc.

I attest that the above information is correct to the best of my knowledge. 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 Name: _____ Patient Signature: _____

MD/RN/RT Signature: _____ Date: _____

Print Name of MD, RN, RT: _____

FOR MRI OFFICE USE ONLY

Patient Name: _____ Patient ID Number: _____

Referring Physician: _____ Procedure: _____

Diagnosis: _____

Clinical History: _____

_____

_____

_____

HAZARD CHECKLIST FOR MRI PERSONNEL

☐ Yes	☐ No	Endotracheal tube	☐ Yes	☐ No	Guidewires
☐ Yes	☐ No	Esophageal Probe	☐ Yes	☐ No	Arterial line transducer
☐ Yes	☐ No	Swan-Ganz catheter	☐ Yes	☐ No	Rectal probe
☐ Yes	☐ No	Tracheotomy tube	☐ Yes	☐ No	Foley catheter with temperature sensor and/or metal clamp
☐ Yes	☐ No	Extra ventricular device			