



MRI SCREENING FORM

The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic or mechanical implants, devices, or objects. Therefore, all individuals are required to fill out this form BEFORE entering the MR environment or MR system room. Be advised, the MR system magnet is ALWAYS on.

<input type="checkbox"/> Open MRI		<input type="checkbox"/> 1.5T High Field MRI			
Patient Name:			Physician Name:		
Weight:		Height:		Age:	
Reason for Test/Area of Concern:					
Current Medications:					
Known drug allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please explain:			
Known allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please explain:			
Recent surgeries or invasive procedures:					
History of cancer, tumor, or lymphoma? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what type:			
Do you have a history of kidney disease or dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No					

	DON'T				DON'T		
	YES	NO	KNOW		YES	NO	KNOW
Cardiac Pacemaker/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shrapnel, Bullets or BBBs If yes, where: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intracranial Aneurysm Clip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Pins, Rods, Screws, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stents/Filters/Shunts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post Op Staples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inner Ear Implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any Other Implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Middle Ear Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Limb or Joining Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carotid Artery Vascular Clamp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid/Wig	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Prosthesis List Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tattooed Eyeliner/Eye Makeup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulator (TENS Unit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dentures, Retainers or Braces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Implanted Insulin Pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Possibility of Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penile Implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earrings or Hair Pins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Piece of Metal in Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previously Worked with Metal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transdermal Patches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orbital/Eye Implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I attest that the above information is correct to the best of my knowledge.

Patient/Nurse Signature

Technologist Signature

Date