

MRI PATIENT SCREENING

Patient Name _____

Procedure _____ Doctor _____

Social Security Number _____ Date of Birth _____

Age _____ Weight _____

CIRCLE CORRECT ANSWER – IF YOU ANSWER “YES” TO ANY OF THE QUESTIONS 1-5, PLEASE NOTIFY SOMEONE

1. Yes No Do you have a pacemaker? If yes, STOP & NOTIFY SOMEONE!
2. Yes No Have you ever had metal fragments in your eyes?
3. Yes No If “yes”, have they been removed? When? _____
4. Yes No Have you ever had brain surgery?
5. Yes No If yes, do you have brain clips?

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS 1-5, PLEASE NOTIFY SOMEONE BEFORE CONTINUING

6. Yes No Do you have removable dental work?
7. Yes No Do you have asthma?
8. Yes No Are you claustrophobic?

THE FOLLOWING ITEMS CAN INTERFERE WITH MRI IMAGING, AND SOME MAY JEOPARDIZE YOUR SAFETY. PLEASE INDICATE WITH A CHECK MARK IF YOU HAVE ANY OF THESE ITEMS IN YOUR BODY.

| | | | |
|-------|----------------------------|-------|---------------------------------|
| _____ | Aortic Clips | _____ | Joint Replacements |
| _____ | Carotid Clips | _____ | Bone or Joint Pins |
| _____ | Heart Valve Replacement | _____ | Prosthesis |
| _____ | Insulin Pump or Port | _____ | Metal Mesh |
| _____ | Infusion Pump (Porta Cath) | _____ | Wire Sutures |
| _____ | Hearing Aids | _____ | Shrapnel/BB's/Buckshot |
| _____ | Cochlear Implant in Ear | _____ | Any other metal or foreign body |
| _____ | Shunt in Brain | _____ | Describe _____ |
| _____ | Penile Implant | | |

Yes No Have you had X-rays of area we are scanning today?
If Yes, when? _____ Where? _____

Yes No Have you had a previous MRI of the area we are scanning today?
Of Yes, when? _____ Where? _____

Yes No Do you, yourself, have a history of cancer?
If yes, where? _____ Do you still have cancer? _____

Women Only

Yes No Are you pregnant at this time?

Yes No Do you have an IUD? If yes, what kind? _____

This procedure will be explained to you and all your questions addressed prior to the MRI scan.

I do not have a pacemaker, nor have I had surgery requiring aneurysm clips. I do not have cochlear implants in the ear, nor do I have metallic foreign bodies in the eye. I am fully aware that if I have any of the above, an MRI scan could be hazardous to my health. The above questions have been answered truthfully, and I agree to the MRI study.

Patient's Signature _____ Date _____