

*****Warning***** certain implants, devices or objects may be hazardous to you and/or may interfere with the MR procedure. **DO NOT ENTER** the MRI system room of the MR environment if you have any questions or concerns regarding an implant, device or object. Consult the MR technologist or radiologist **BEFORE** entering the MRI system room. The MRI system magnet is **ALWAYS** on.
If you have a stent or implant, please provide the type and year installed.

Please answer no or yes to the following questions:

	YES	NO		YES	NO
Aneurysm clips	<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid (must be removed)	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Body piercing or jewelry	<input type="checkbox"/>	<input type="checkbox"/>
Implanted cardioverter defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Eyelid spring or wire	<input type="checkbox"/>	<input type="checkbox"/>
Electronic/Magnetically-activated implant	<input type="checkbox"/>	<input type="checkbox"/>	Artificial or prosthesis	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulation system	<input type="checkbox"/>	<input type="checkbox"/>	Radiation seed or implants	<input type="checkbox"/>	<input type="checkbox"/>
Spinal cord stimulator	<input type="checkbox"/>	<input type="checkbox"/>	Wire mesh implant	<input type="checkbox"/>	<input type="checkbox"/>
Dentures or partial plates	<input type="checkbox"/>	<input type="checkbox"/>	Tissue expander {i.e. breast}	<input type="checkbox"/>	<input type="checkbox"/>
Tattoo or permanent makeup	<input type="checkbox"/>	<input type="checkbox"/>	IUD, diaphragm or pessary	<input type="checkbox"/>	<input type="checkbox"/>
Internal electrode or wires	<input type="checkbox"/>	<input type="checkbox"/>	Bio-stimulator	<input type="checkbox"/>	<input type="checkbox"/>
Bone growth/bone fusion stimulator	<input type="checkbox"/>	<input type="checkbox"/>	Penile implant	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear, otologic or other ear implant	<input type="checkbox"/>	<input type="checkbox"/>	Spinal fixation device	<input type="checkbox"/>	<input type="checkbox"/>
Insulin or other infusion pump	<input type="checkbox"/>	<input type="checkbox"/>	Spinal fusion procedure	<input type="checkbox"/>	<input type="checkbox"/>
Implanted drug infusion device	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve or any type prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Breathing problem	<input type="checkbox"/>	<input type="checkbox"/>
Metallic stent, filter or coil	<input type="checkbox"/>	<input type="checkbox"/>	Vascular access port and/or catheter	<input type="checkbox"/>	<input type="checkbox"/>
Shunt {spinal or intraventricular}	<input type="checkbox"/>	<input type="checkbox"/>	Medication patch {nicotine}	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement [hip, knee, etc.]	<input type="checkbox"/>	<input type="checkbox"/>	Surgical staples, clips, or metallic suture	<input type="checkbox"/>	<input type="checkbox"/>
Swan-Ganz or thermo dilution catheter	<input type="checkbox"/>	<input type="checkbox"/>	Any implanted items (pins, rods, screws)	<input type="checkbox"/>	<input type="checkbox"/>
Any metallic fragment or foreign body	<input type="checkbox"/>	<input type="checkbox"/>			

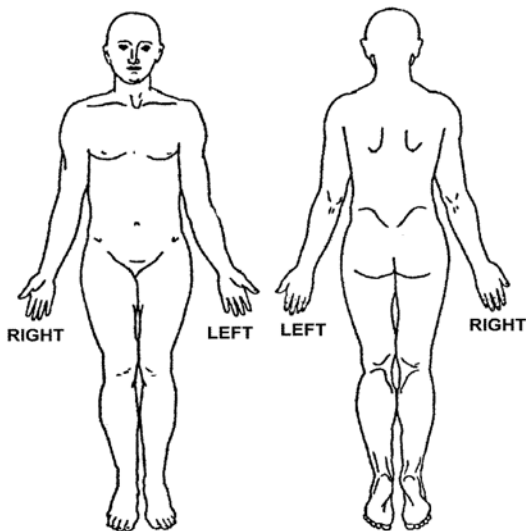
I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Patient _____ Today's Date _____

Form completed by: Patient _____ Relative _____ Relationship to patient: _____

Tech Signature _____

Please circle area of pain on the drawing below to the left.



Instructions:

- Remove all jewelry
- Remove hearing aids
- Ear plugs will be provided
- Remove all hairpins, barrettes, etc.
- Remove all dentures (leave in locker)
- Remove body piercings
- Remove watch, pager, cell phones, wallet, credit cards, etc.



MRI PATIENT SAFETY QUESTIONNAIRE

Patient Name _____ DOB ____/____/____

Weight _____ Reason for MRI/Symptoms: _____

Date of injury _____ Workman's comp Yes ___ No ___

Have you had any previous surgery on the part of your body that we are scanning today? Yes ___ No ___

Please list any surgeries you ever had and date(s):

DATE TYPE OF SURGERY

Blank lines for listing surgeries with date and type columns.

Are you allergic to any medication? If yes, please list: _____

Have you done work involving welding or grinding of sheet metal?
Have you ever had any metal pieces or fragments in your eye?
[] No [] Yes

For Female Patients

Date of Last menstrual period: ____/____/____ Post Menopausal? [] No [] Yes
Are you pregnant or experiencing a late menstrual period? [] No [] Yes
Are you currently breast-feeding? [] No [] Yes

Please answer the following: Creatinine: _____ GFR: _____

Current or past history of Cancer [] No [] Yes what type of Cancer _____
Diabetic [] No [] Yes
Hepatic/Liver Disease [] No [] Yes Kidney or Liver Transplant [] No [] Yes
High Blood Pressure [] No [] Yes currently on dialysis [] No [] Yes
Kidney Problems or 1 kidney [] No [] Yes Over 60 years old [] No [] Yes

Have you had prior imaging studies that pertain to your MRI? [] No [] Yes
(X-ray, CT, Ultrasound, Bone Scan or Nuc Med)

Where: _____ When: _____ Body Part: _____
Where: _____ When: _____ Body Part: _____
Where: _____ When: _____ Body Part: _____