MRI SAFETY SCREENING

Subject ID: _____ **Subject date of birth:** _____

Allergies:_____ Height (in/cm):_____ Weight (lbs/kgs):_____

Any surgery in the last 8 weeks Yes _____ No_____
If yes, what kind_____

***** CANNOT BE SCANNED** ****REQUIRES DOCUMENTATION AND APPROVAL** ***MORE INFORMATION NEEDED**

Have you ever had any of the following surgeries /implants?

***Implanted neurological or spinal stimulator ..... yes ..... no ..... don't know
***Pacemaker or pacemaker wires ..... yes ..... no ..... don't know
***Implanted cardiac defibrillator or heart pump (LVAD) ..... yes ..... no ..... don't know
**Aneurysm clip(s) or surgery ..... yes ..... no ..... don't know
**Artificial heart valve or heart stent(s) ..... yes ..... no ..... don't know
*Heart surgery ..... yes ..... no ..... don't know
*Brain surgery ..... yes ..... no ..... don't know
*Middle ear implant ..... yes ..... no ..... don't know
*Cataract surgery/eye lens implant ..... yes ..... no ..... don't know
*Any other implanted mechanical/electrical device or wires ..... yes ..... no ..... don't know
*Other surgeries or implants? If yes, what kind_____

**Have you ever had a piece of metal flushed/removed from your eye? ..... yes ..... no
*Have you ever been a machinist, welder or metal worker? ..... yes ..... no

Do you have any of the following items in/on your body (circle them)?

blood clot filter**	IUD/implanted contraceptive*	shunt**
metal tracheostomy***	medication patch (Please remove prior to MRI)*	
wires/plates/screws/pins*	penile prosthesis**	stents**
bullets/BBs/pellets***	shrapnel/metal fragments ***	coils**
infusion pump**	bone growth stimulator***	hearing aid*
silver based ointment***	dental implants/retainers*	braces***
breast tissue expanders***	small bowel endoscopy capsule***	surgical clips*
artificial hair/wig*	hairpins/bobby pins*	artificial limb or joint*

Do you have a tattoo, permanent make-up or body piercing? .... ……yes….. no
Can you stand without assistance? ..... …… yes….. no
Are you claustrophobic? .... yes …. no
Are you mentally impaired? .... yes …. no
Do you have uncontrollable shaking? .... yes …. no
Are you currently using a Broviac, Swan-Ganz or other thermodilution catheter ..... yes …. no
Are you wearing antimicrobial or other metallic fiber clothing?..... yes ..... no ..... don't know
Can you lie still on your back for 1 hour? ..... yes ..... no ..... don't know
Are you pregnant? ..... yes ..... no ..... not sure
Do you require vision correction?..... yes ..... no ..... not sure
*If yes, please wear contacts or bring your prescription information (if available)

IMPORTANT INSTRUCTIONS: THE MR SYSTEM MAGNET IS ALWAYS ON!!!
PLEASE REMOVE ALL BODY PIERCINGS/JEWLERY/HAIRPINS/BELTS AND ANY OTHER METAL OBJECTS BEFORE ENTERING THE MR PROCEDURE ROOM.

_____
Initial Here

Subject Signature:_____
(parent/guardian if under 18)
Date:_____

Technologist Signature:_____

Type of implants/surgeries/foreign body:
_____

Approved By:_____

Signature/Date:_____