MRI SAFETY SHEET

(Please circle or fill in the blanks)

Patient Name:____________________**DOB:**_________ **Age:** _________ **Gender:** ______ **MRN:**_________

Smoker: ☐YES ☐NO ☐FORMER **Height:**______________ **Weight:**________________

Emergency Contact Person:_________________________ **Phone:**___________________________

Reason for MRI and/ or Symptoms: ____

1. Have you had prior surgery (operation, biopsy etc.) of any kind? (Please list below surgery type & date) ☐**YES** ☐**NO**

____

____

____

2. Have you had an endoscopy within last 2 weeks (colonoscopy, upper GI, arthroscopy, etc.)? ☐**YES** ☐**NO**

3. List previous exams or test related to body part being scanned today. ☐**YES** ☐**NO**

MRI_________________(Body Part)____________(Date)_______________(Facility)
CT_________________(Body Part)____________(Date)_______________(Facility)
X-Ray_________________(Body Part)____________(Date)_______________(Facility)
Ultrasound_________________(Body Part)____________(Date)_______________(Facility)
Other_________________(Body Part)____________(Date)_______________(Facility)

4. Have you ever experienced any problems related to a previous MRI exam or procedure? ☐**YES** ☐**NO**
5. Have you had an injury to the eye involving a metallic object or fragment (metallic slivers etc.)? ☐**YES** ☐**NO**
   If yes, did you receive medical attention for the eye injury ☐**Yes** ☐**No**
6. Have you ever been injured by metallic object or foreign body (bullet, shrapnel, BB etc)? ☐**YES** ☐**NO**
7. Are you currently taking or have you recently taken any medications or drugs? (If yes, list below) ☐**YES** ☐**NO**

   ____

8. Do you have any allergies? (If yes, list below) ☐**YES** ☐**NO**

   ____

9. Do you have asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT or X-ray? ☐**YES** ☐**NO**
10. Do you have renal (kidney) disease, kidney failure, kidney transplant, acute kidney injury (AKI) ☐**YES** ☐**NO**
11. Do you have Hypertension? (High Blood Pressure) ☐**YES** ☐**NO**
12. Do you have diabetes? ☐**YES** ☐**NO**
13. Do you have Seizure disorder? ☐**YES** ☐**NO**
14. Do you have Anemia or other blood disorder? ☐**YES** ☐**NO**
15. Do you have Liver (hepatic) disease? ☐**YES** ☐**NO**
16. Have you ever been or currently being treated for cancer? Type________________________ ☐**YES** ☐**NO**

FOR FEMALE PATIENTS ONLY:

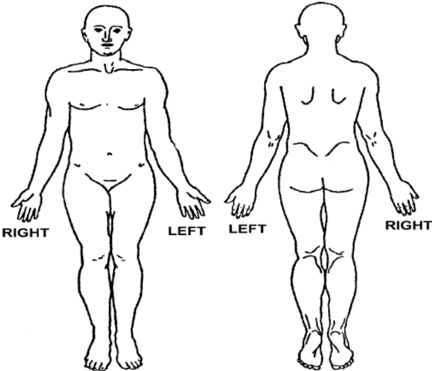
17. Date of last menstrual period (mm/dd/yr) ____/____/_____ Post-Menopausal ☐
18. Are you pregnant or experiencing a late menstrual period? ☐**YES** ☐**NO**
19. Are you taking oral contraceptives, hormone treatments, or hormone replacement therapy ☐**YES** ☐**NO**
20. Are you currently breastfeeding? ☐**YES** ☐**NO**
21. Are you taking any type of fertility medication or having fertility treatments ☐**YES** ☐**NO**

    If yes, please list____

MRN: ____________

Warning: Certain Implants, devices or objects may be hazardous to you and/or may interfere with the MR procedure. **DO NOT ENTER** the MR scan room or MR environment if you have any questions or concerns regarding an implant, device, or object. Consult the MR Technologist or Radiologist BEFORE entering the MR room. We **strongly** recommend using ear plugs or headphones for your MR exam since some patients may find noise levels unacceptable. **The MR system is ALWAYS on.**

Aneurysm Repair or clips ☐Brain ☐Abdomen	**☐YES ☐NO**	Artificial limb (prosthesis) List_____________________________	**☐YES ☐NO**
Cardiac Pacemaker or pacing wires Type________ Model #________________	**☐YES ☐NO**	Other Implant List:_____________________________	**☐YES ☐NO**
Implanted cardioverter defibrillator	**☐YES ☐NO**	Radiation Seed or Implants	**☐YES ☐NO**
Electronic implanted device	**☐YES ☐NO**	Swan-Ganz or Thermodilution Catheter	**☐YES ☐NO**
Magnetically activated implant or device	**☐YES ☐NO**	Medication patch (nicotine, nitro, birth control)	**☐YES ☐NO**
Neurostimulation system	**☐YES ☐NO**	Any metal fragments or foreign bodies	**☐YES ☐NO**
Spinal Cord stimulator	**☐YES ☐NO**	Wire mesh implant	**☐YES ☐NO**
Internal electrodes or wires	**☐YES ☐NO**	Tissue expanders (ie., breast)	**☐YES ☐NO**
Bone growth/ bone fusion stimulator	**☐YES ☐NO**	Surgical staples, clips, metallic sutures	**☐YES ☐NO**
Cochlear, otologic, stapes, or any ear implant	**☐YES ☐NO**	Joint Replacements	**☐YES ☐NO**
Insulin or other infusion or IV pump	**☐YES ☐NO**	Pins, screws, nail, wires, plates in body	**☐YES ☐NO**
Implanted drug infusion device	**☐YES ☐NO**	IUD, Diaphragm, or pessary	**☐YES ☐NO**
Foley catheter with temperature sensor	**☐YES ☐NO**	Dentures, partial plates (remove)	**☐YES ☐NO**
Any type prosthesis (eye, penile implant etc.)	**☐YES ☐NO**	Magnetic Dental Implants	**☐YES ☐NO**
Pill Cam Capsule (endoscopy device)	**☐YES ☐NO**	Tattoos or permanent cosmetics	**☐YES ☐NO**
Heart Valve replacement or prosthesis	**☐YES ☐NO**	Body piercing jewelry (remove)	**☐YES ☐NO**
Eyelid spring, wire, or eyelid weights	**☐YES ☐NO**	Body Modification implants	**☐YES ☐NO**
Lens Implant, IMT lens implant, retinal tack	**☐YES ☐NO**	Hearing Aids (remove)	**☐YES ☐NO**
Stent, Filters, Coil	**☐YES ☐NO**	Magnetic False Eyelashes (remove)	**☐YES ☐NO**
Vascular access port or catheter (porta-cath)	**☐YES ☐NO**	Claustrophobia	**☐YES ☐NO**
Shunt-spine or brain (intraventricular)	**☐YES ☐NO**		



Mark on figure(s) of any implant or metal in or on your body.

Important Instructions: Before entering the MR environment or MR systems room, you must remove all metallic objects including hearing aids, keys, beeper, cell phone, hair pins, barrettes, jewelry, body piercing, watch, safety pins, paperclips, money clip, credit cards/magnetic strip cards, coins, pens, pocket knives, lighters, nail clippers, tools, dentures, clothing with metal or metallic thread. Please consult MR technologist if you have any questions **BEFORE** you enter the MR scan room.

GADOLINIUM (CONTRAST) INJECTIONS: Your MRI exam may include an injection of gadolinium-based MR contrast to help enhance certain structure in the body. Gadolinium is FDA approved. You must inform the MR technologist if you have impaired or reduced kidney function. On rare occasions, allergic-type reactions (hives/ itching) and other adverse events have occurred. The safety of injecting gadolinium in children under two years old, pregnant women, and nursing mothers has not yet been determined. Our staff is available to answer questions you may have regarding the gadolinium

Medication Guide offered to patient? **☐YES** **Reviewed by Technologist________________**

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 I am about to undergo. I hereby give my consent for the MRI examination.

Signature of Person Completing ________________________________ Print Name_____________________ Date______________

☐Patient☐ Nurse ☐Relative ________________ (Relationship)☐ POA______________ Relationship)

 MRN: _____________