



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

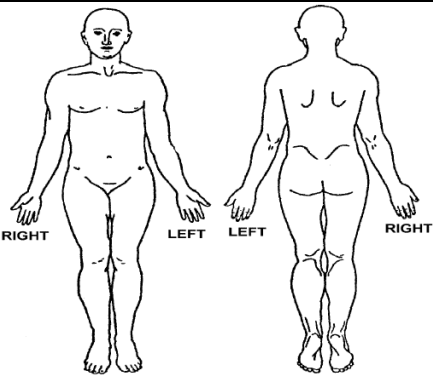
21. Are you taking any type of fertility medication or having fertility treatments YES NO

If yes, please list _____



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