MR Patient Safety Screening / Questionnaire Form

Date: Name: DOB: Height: Weight:

Please circle Yes or No for each of the following:

Y N	Can you lie flat and still for at least 45 mins?	Y N	Vascular artery or vein stent (including coronary stent
Y N	Do you have difficulty holding your breath?	Y N	Vascular artery, vein or aneurysm clip or coil
Y N	Claustrophobic, anxiety, emotional distress	Y N	IVC filter
Y N	Prior allergic reaction to MR / gadolinium IV contras	Y N	Chest port, PICC/TICC line or dialysis catheter
Y N	Hypertension	Y N	Swan-Ganz / thermodilution catheter
Y N	Diabetes mellitus	Y N	Artificial/prosthetic limb
Y N	Renal disease/failure (including dialysis)	Y N	Joint replacement (hip, knee, shoulder, elbow, ankle)
Y N	History of seizures	Y N	Fracture fixation plate, rod or wires
Y N	Electrodes/leads inside your body	Y N	Surgical clips, staples or mesh material
Y N	Eye injury involving a metal object/fragment	Y N	Bowel endoscopic pill camera within last 6 weeks
Y N	Bullet/buckshot/BB/shrapnel injury with fragments remaining inside your body	Y N	Upper endoscopy / colonoscopy within last 3 months
		Y N	Inspire (upper airway) stimulator for sleep apnea
Y N	Hearing aid, cochlear implant or other ear implant	Y N	Sacral/bladder stimulator (InterStim device)
Y N	Eyelid weight, spring or wire	Y N	Insulin or other drug infusion pump
Y N	Ventricular peritoneal shunt Is it programmable or nonprogrammable?	Y N	Medication patch (lidocaine/nicotine/nitroglycerine)
Y N	Brain aneurysm or other vascular clip or coil	Y N	IV iron infusion therapy within last 6 months (Injectafer, Ferrlecit, Feraheme, Venofer)
Y N	Deep brain stimulator	Y N	Electronic monitor attached to skin (e.g. glucose or ankle monitor)
Y N	Vagus or other peripheral nerve stimulator		
Y N	Spinal cord stimulator	Y N	Breast tissue expander
Y N	Intrathecal (spine) pain pump	Y N	Penile implant/prosthesis
Y N	Lumbar (spine) peritoneal shunt	Y N	Magnetic cosmetic including eye lashes, contacts, hair products or nail polish
Y N	Cardiac pacemaker or defibrillator (ICD)		
Y N	Cardiac event (loop) recorder	Y N	Permanent makeup, eyeliner or tattoo
Y N	Heart valve replacement, prosthesis or repair	Y N	Body piercing or other jewelry

For Female patients:

	Date of last menstrual cycle?	Y N	Are you pregnant or experiencing a late cycle?
Y N	Post menopausal, hysterectomy or tubal ligation?	Y N	Are you currently breast feeding?

List any metallic, electronic or magnetic implants inside your body not listed above:

What is the purpose of today's MR exam? What symptoms are you having?

Please list any medical conditions which you are currently being treated for:

Please list any cancerous conditions that you have ever been treated for and provide approximate dates:

Please list any surgeries that you have had:

MR Exam Preparation Information

- You will be given MRI safe clothing to change into prior to exam. Some clothing contains metallic material that is not apparent. This clothing has been reported to heat during MRI exams and can cause injury/burns. All STREET clothes will need to be removed.
- Please remove all metallic objects including: hearing aids; eyeglasses; hairpins, clips or barrettes; cell phone; keys, watches; car keys; coins; credit cards (or other magnetic strip cards); jewelry; body piercing; safety pins; pens; pocket knives and other tools; firearms and vape devices.
- You will be given ear plugs (or other hearing protection) to wear during the MRI exam to protect you from any loud noises that may occur during your examination.

I attest that the information provided above is correct to the best of my knowledge. I understand the contents of this form and have been given the opportunity to ask questions regarding this form and the MR exam. The MR technologist answered any questions I had satisfactorily.

Patient/Caregiver Signature: Date:

Patient/Caregiver Printed Name: Relation to Patient:

Tech Signature & Printed Name: