Safety Screening Form

Magnetic Resonance (MR) Procedures

Date: _____

Name (first, middle, last): _____ _____

Gender: Male ☐ Female ☐ Age: _____ Date of Birth: _____

Height: Weight:

If uncertain of any answer below, please circle and leave blank to discuss with the coordinator.

Why are you having this examination (medical problem)?

_____

List current medications:

☐ None

_____

_____

Allergies to Gadolinium

☐ Yes ☐ No

If yes, please describe _____

_____

Females Only: Date of last menstrual period _____

☐ Yes ☐ No Is there a possibility that you are pregnant?

☐ Yes ☐ No Are you post-menopausal?

☐ Yes ☐ No Are you breast feeding?

Please indicate if you have or have not had any of the following

☐ Yes ☐ No Previous MRI examination

Facility name and city _____

Date of examination _____

Body part imaged _____ Reason for imaging_____

☐ Yes ☐ No Surgery of any kind

If yes, list all prior surgeries and approximate dates _____

_____

Safety Screening for Magnetic Resonance (MR) Procedures

☐ Yes ☐ No Injury by a metal object or foreign body (e.g., bullet, BB, shrapnel)
If yes, explain _____

☐ Yes ☐ No Injury to your eye from a metal object

☐ Yes ☐ No If yes, did you seek medical care?
If yes, describe what was found _____

☐ Yes ☐ No Foreign body removed from eye
If yes, describe what was taken out _____

☐ Yes ☐ No Spinal fusion procedure

☐ Yes ☐ No Endoscopy or colonoscopy in last two months

The following items may be harmful to you during your MR scan and may interfere with the MR examination. You must provide a "Yes" or "No" answer for every item.

Please indicate if you CURRENTLY HAVE or HAVE EVER HAD any of the following:

Surgically implanted medical devices

☐ Yes ☐ No Any type of electronic, mechanical or magnetic implant
If yes, list type _____

☐ Yes ☐ No Cardiac pacemaker, defibrillator or other cardiac implant (in place or removed)

☐ Yes ☐ No Aneurysm Clip

☐ Yes ☐ No Neurostimulator, diaphragmatic stimulator, deep brain stimulator, vagus nerve stimulator, bone growth stimulator, spinal cord stimulator, or any biostimulator (in-place or removed)
If yes, list type _____

☐ Yes ☐ No Any type of internal electrodes or wires

☐ Yes ☐ No Ear or Cochlear implant

☐ Yes ☐ No Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)

☐ Yes ☐ No Spinal fixation device

☐ Yes ☐ No Any type of coil, filter or stent
If yes, list type _____

☐ Yes ☐ No Artificial heart valve

☐ Yes ☐ No Penile implant

☐ Yes ☐ No Artificial eye

☐ Yes ☐ No Eyelid spring and/or eyelid weight

☐ Yes ☐ No Any type of implant held in place by a magnet

☐ Yes ☐ No Implanted port (Port-a-Cath, Mediport, Powerport)

☐ Yes ☐ No Tissue Expander (e.g., breast)

☐ Yes ☐ No Surgical mesh
If yes, location _____

Safety Screening for Magnetic Resonance (MR) Procedures

☐ Yes ☐ No Ventricular Shunt

☐ Yes ☐ No Artificial Limb
If yes, which limb and which side of the body _____

☐ Yes ☐ No Intrauterine device (IUD) or other implanted contraceptive

Removable medical devices

☐ Yes ☐ No Hearing aid

☐ Yes ☐ No Removable drug pump (e.g., insulin, Baclofen, Neulasta)

☐ Yes ☐ No Glucose monitoring Device (Freestyle or similar)
If yes, type _____

☐ Yes ☐ No Medication Patch (eg. Nitroglycerine, Nicotine)

☐ Yes ☐ No Removable dentures, false teeth or partial plate

☐ Yes ☐ No Diaphragm, pessary
If yes, type _____

☐ Yes ☐ No Have you recently ingested a "pill cam?"
If yes, date "pill cam" was ingested _____

Personal

☐ Yes ☐ No Body piercings
If yes, location _____

☐ Yes ☐ No Wig, hair implants

☐ Yes ☐ No Tattoos or tattooed eyeliner

☐ Yes ☐ No Any hair accessories (e.g., bobby pins, barrettes, clips, extensions, weaves)

☐ Yes ☐ No Jewelry

☐ Yes ☐ No Metal-containing clothing material and/or underwear

☐ Yes ☐ No Magnetic cosmetics and hair care (e.g., magnetic eyelashes, magnetic nail polish)

☐ Yes ☐ No Electronic monitoring or tagging equipment (e.g., ankle monitor)

☐ Yes ☐ No Fitness tracker/biomonitor (e.g., Fitbit)

☐ Yes ☐ No Any other type of surgically implanted medical devices, removable medical devices or personal items not covered above? (Pins, Rods, Screws, Nails, Plates, Wires etc.)

If yes, type _____

I have read and understand the entire content of this form.

Patient signature: _____

MD/RN/RT signature: _____

MD/RN/RT printed name: _____

Date: _____