

MRI PATIENT SCREENING FORM

The information requested on this form is **very important**. Please answer **all** questions as thoroughly as possible.
The person completing this form is responsible for the accuracy of the requested information.

Patient Name: _____ Appointment Date: _____
 Date of Birth: _____ Weight: _____

YES	NO		YES	NO	
		CARDIAC PACEMAKER-NOTIFY TECH			Breast Tissue Expander
		Implanted Cardiovascular Defibrillator			Penile Implant
		Stent, Coil or Filter Location: _____ Date: _____			Neuro-Stimulation System
		Aneurysm Clips Location: _____			Bone Growth/Bone Fusion Stimulator
		Surgical Staples, Clips or Metallic Sutures			Middle Ear/Cochlear Implant
		Carotid Artery Clips Date: _____			Left _____ Right _____ Both _____
		Internal electrodes or wires			Prosthesis of any kind? Location: _____ Date: _____
		Eyelid Spring or Wire			Foley catheter with temperature probe
		Artificial Heart Valve Date: _____			Thermodilution Swan-Ganz catheter
		Hearing Aid			Implanted Drug Infusion Pump
		Intrauterine Device IUD			Medication Pump
		Shunt: Spinal or Ventricular			Metal Fragments (Shrapnel or gunshot Wound)
		Fractured bones or spine treated with:			Location: _____ Date: _____
		Metal Rods Date: _____			Magnetically Activated Implant or Device?
		Metal Plates Date: _____			Allergic Reactions to IV Contrast?
		Metal Pins/screws Date: _____			Have you been/are you now being treated for kidney problems?
		Ph Graph Probe			Are you pregnant or trying to get pregnant?
		Medication Patch			Are you Breast Feeding?
		Metal in eyes			Tattoos/Permanent Makeup Location: _____
		Left _____ Right _____ Both _____			Body Piercing Location: _____
		Sickle Cell Anemia			Other Implants Location: _____
		EKG leads or test done recently			Wig or Hairpiece
		Silver Impregnated wound dressing			Ingested camera pill

No one should enter the MRI scan room with any of the following items:

- Watch • Metal Zippers • Firearms • Removable Dental Work • Hearing Aid • Keys/Coins • Pocket Knife
- Hairpins/Accessories • Pens/Pencils • Belt Buckle • Bra • Purse/Wallet/Money Clip/Credit Cards

Signature of person completing form X _____ Date: _____

Form completed by: Patient Relative

MRI STAFF: Signature of person reviewing form: X _____

Were plain films obtained? _____ Films cleared by: _____

CONTRAST: _____ AMOUNT: _____ LOT# _____ EXPIRATION: _____