**PRE-MRI SAFETY SCREENING**

Referring Physician:

Name:

D.O.B:

Sex:

Height:

Weight:

Date:

MRN#

Technologist Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please indicate if you have any of the following:**

 **YES NO Aneurysm clip(s)**

 **YES NO Cardiac pacemaker**

 **YES NO Implanted cardiac defibrillator (ICD)**

**Health History:**

 **YES NO Claustrophobia**

 **YES NO Cancer (If yes, type/treatment)**

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 **YES NO Drug allergies (If yes, describe)**

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 **YES NO Pregnant, or think you may be?**

**Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **YES NO Breast feeding**

 **YES NO Kidney disease**

 **YES NO Are you on Dialysis?**

 **YES NO Injury related to today’s exam?**

**Date of injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Work or MVA**

 **YES NO Any surgery in the last 6 weeks?**

 **YES NO Have you had any surgery on the**

 **part of your body being**

 **examined today?**

**If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List all prior surgical procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_**

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 **Describe why you are having this exam done today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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 **YES NO Magnetically-activated implant or device**

 **YES NO Electronic implant or device**

 **YES NO Neurostimulation system**

 **YES NO Spinal cord stimulator**

 **YES NO Internal electrodes or wires**

 **YES NO Bone growth/bone fusion stimulator**

 **YES NO Cochlear or other ear implant**

 **YES NO Insulin or other infusion pump**

 **YES NO Implanted drug infusion device**

 **YES NO Any type of prosthesis (eye, penile, etc.)**

 **YES NO Heart valve prosthesis**

 **YES NO Eyelid spring, wire, or artificial eye**

 **YES NO Artificial or prosthetic limb**

 **YES NO Metallic stent filter or coil**

 **YES NO Shunt (spinal or intraventricular)**

 **YES NO Vascular access port and/or catheter**

 **YES NO Radiation seeds or implants**

 **YES NO Any metallic fragment or foreign (BB, bullet, shrapnel)**

 **YES NO Wire mesh implant**

 **YES NO Tissue expander (e.g. breast)**

 **YES NO Surgical staples, clips, or metallic sutures**

 **YES NO Joint replacement (hip, knee, etc.)**

 **YES NO Bone/joint pin, screw, nail, wire, plate, etc.)**

 **YES NO IUD, diaphragm, or ring**

 **YES NO Dentures or partial plates**

 **YES NO Tattoo or permanent makeup**

 **YES NO Body piercing jewelry**

 **YES NO Wig or hair implant**

 **YES NO Have you ever been a welder, grinder or sheet metal worker?**

 **YES NO Have you ever had an injury involving a metallic object or fragment?**

 **YES NO Hair accessories?**

 **YES NO Hearing aid (Remove before entering MRI)**

 **YES NO Other implant**

 **YES NO Medication patch**

Technologist Signature: Date: Time:

Patient Signature: Date: Time: