**PRE-MRI SAFETY SCREENING**

Referring Physician:

Name:

D.O.B:

Sex:

Height:

Weight:

Date:

MRN#

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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: