



MRN: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
PATIENTS WEIGHT: \_\_\_\_\_  
DATE: \_\_\_\_\_

## MRI Safety Screening Form



**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure i.e., MRI, MR angiography, functional MRI, MR spectroscopy) **Do Not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object Consult the MRI Technologist or Radiologist BEFORE entering the MR system room **The MR system magnet ALWAYS on.**

**NOTE:** You May be advised or required to wear earplugs or other hearing protection during the MRI procedure to prevent Possible problems or hazards related to acoustic noise.

Please indicate you have the following:

- |                              |                             |  |                              |                             |                                 |
|------------------------------|-----------------------------|--|------------------------------|-----------------------------|---------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted cardioverter defibrillator (ICD)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aneurysm clip(s)                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Magnetically-activated implant or device     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cardiac pacemaker               |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone growth/bone fusion stimulator           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Electronic implant or           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cochlear, otologic, or other ear implant     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurostimulation system         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Insulin or other infusion pump               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Spinal cord stimulator          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted drug infusion device               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Internal electrodes or          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any type of prosthesis (eye, penile, etc.)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eyelid spring or wire           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shunt (spinal or intraventricular)           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial or prosthetic limb   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vascular access port and/or catheter         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metallic stent, filter, or coil |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swan-Ganz or thermodilution catheter         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation seeds or implants     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Medication patch (Nicotine, Nitroglycerine)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wire mesh implant               |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any metallic fragment or foreign body        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | IUD, diaphragm, or pessary      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tissue expander (e.g. breast)                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dentures or partial plates      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgical staples, clips, or metallic sutures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Body piercing jewelry           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint replacement (hip, knee, etc.)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing aid                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone/joint                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breathing problem               |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tattoo or permanent makeup                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Claustrophobia                  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other implant _____                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pregnancy                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Endoscopy Capsule                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tracheostomy                    |

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?  
If yes, please indicate date and type of surgery: Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Type of surgery \_\_\_\_\_

2. Have you had an injury to the eye involving a metallic object (e.g., metallic slivers, foreign body)?  
If yes, please describe: \_\_\_\_\_

3. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?  
If yes, please describe: \_\_\_\_\_

4. Are you pregnant or suspect that you are pregnant?

List medications currently taking \_\_\_\_\_  
\_\_\_\_\_

**continued - over** →



R A 2 C 2 4 4

I attest that the above information is correct to the best of my knowledge I read and understand the comments of this form and had the opportunity to ask questions regarding the information on this form and regarding and MR procedure that I am about to undergo.

Signature of Patient/Guardian completing form: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Time \_\_\_\_\_

Form Completed By:  Patient  Relative  Nurse \_\_\_\_\_ Relationship to Patient

Form Information Reviewed By: \_\_\_\_\_ Print Signature

Date \_\_\_\_\_ Time \_\_\_\_\_

MRI Technologist  Nurse  Radiologist  Other \_\_\_\_\_

Approved for 1.5T

Approved for 3.0T



**IMPORTANT INSTRUCTIONS**

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.