SUNY DOWNSTATE Medical Center
University Hospital of Brooklyn

MRI ASSESSMENT CHECKLIST

Patient Name______________________________ MR#__________

Age________ Weight_______

1. Have you ever had an MRI? YES_____ NO______ Date of last MRI:__________.

A. Are you able to lie flat/still during procedure?	YES__	NO____
B. Are you claustrophobic?	NO__	YES____
C. Have you ever had surgery?	NO__	YES____
If yes, please list all procedures and___________ date__________		
2. Have you had an injury to the eye involving a metallic object or fragment?	NO__	YES____
3. Do you have any of the following items in or on your body?		
Hearing Aid	NO__	YES____
Pacemaker:	NO__	YES____
Implanted electrical device:	NO__	YES____
Ear/Cochlear implant:	NO__	YES____
Neurostimulators:	NO__	YES____
Brain/Aneurysm clips:	NO__	YES____
Stents:	NO__	YES____
Metal fragments/shrapnel	NO__	YES____
Magnetic dental implants:	NO__	YES____
Tattoo:	NO__	YES____
Nicotine patch:	NO__	YES____
4. Have you ever had a gunshot injury? If yes, where in your body?__________	NO__	YES____
5. Are there any bullet fragments left inside of you?	NO __	YES____
6. Any other metal objects or implants?	NO__	YES____
If yes, please give name and date of implant__________________________		
7. Have ferromagnetic objects been removed?	YES__	NO____
8. Have you ever worked as a welder or a metal grinder?	NO__	YES____

9. Have you ever had an injection of contrast for an MRI? NO__ YES____

If yes, did you experience any of the following:

a. Hives:	NO__	YES____
b. Shortness of breath	NO__	YES____
c. Fainting or collapse	NO__	YES____
10. Is there any possibility of pregnancy? LMP: DATE___________.	NO__	YES____
11. Are you breast-feeding?	NO__	YES____
12. Is patient on any form of isolation?	NO__	YES____
13. Patient understands that there is communication with the technologist during the scan .	YES__	NO ____

ASSESSMENT PERFORMED BY: (PRINT NAME) ________________________ DATE____________

(SIGN NAME)________________________ TITLE________________

PATIENT OR GUARDIAN SIGNATURE: ________________________ DATE________________

RELATIONSHIP TO PATIENT: SELF____________ OTHER________________

REVIEWED BY: (PRINT NAME)________________________ DATE__________

(SIGN NAME)________________________ TITLE________________

Notes:____

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