

Please help us prepare for your exam by answering the questions below

Date _____ Name _____ MR# _____ Gender: Male Female

DOB _____ Referring Physician _____

Reason for MRI/Symptoms _____

GENERAL PATIENT INFORMATION

ARE YOU **PREGNANT** OR **BREAST FEEDING**? YES NO N/A

If you answer **YES** to any of the following - **STOP** and alert the staff **NOW**. Do you have:

MRI PATIENT SAFETY CHECKLIST			YES	NO	MAKE	MODEL		
1. Pacemaker/defibrillator/loop recorder			<input type="checkbox"/>	<input type="checkbox"/>				
2. Cerebral aneurysm clips			<input type="checkbox"/>	<input type="checkbox"/>				
3. Ear Implants			<input type="checkbox"/>	<input type="checkbox"/>				
4. Spinal cord stimulator			<input type="checkbox"/>	<input type="checkbox"/>				
5. Implanted infusion pump			<input type="checkbox"/>	<input type="checkbox"/>				
	YES	NO	YES	NO		YES	NO	
Brain Clips	<input type="checkbox"/>	<input type="checkbox"/>	Metal Mesh	<input type="checkbox"/>	<input type="checkbox"/>	Shrapnel	<input type="checkbox"/>	<input type="checkbox"/>
Aortic Clips	<input type="checkbox"/>	<input type="checkbox"/>	Metal tracheotomy	<input type="checkbox"/>	<input type="checkbox"/>	Hairpins/Hairclips	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Penile implants	<input type="checkbox"/>	<input type="checkbox"/>	Permanent eyeliner	<input type="checkbox"/>	<input type="checkbox"/>
IVC filter(umbrella)	<input type="checkbox"/>	<input type="checkbox"/>	IUD	<input type="checkbox"/>	<input type="checkbox"/>	Tattoos	<input type="checkbox"/>	<input type="checkbox"/>
Shunts	<input type="checkbox"/>	<input type="checkbox"/>	Denture	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Stents	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>	Are you a metal worker?	<input type="checkbox"/>	<input type="checkbox"/>
Limb prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Electrodes	<input type="checkbox"/>	<input type="checkbox"/>	Metal in the eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Rods or Screws	<input type="checkbox"/>	<input type="checkbox"/>	Bullet Fragments	<input type="checkbox"/>	<input type="checkbox"/>	Any other metal	<input type="checkbox"/>	<input type="checkbox"/>

What is your weight? _____ height? _____

Patient Signature:

Date: _____

List of **SURGERIES**: _____

Family/MRI Rep. screened according to above criteria? YES NO

MRI Representative Title: _____

(Signature of MRI Rep.) Date: _____

Intepreter needed: YES NO

Name: _____ Date: _____

Δ WARNING: CERTAIN IMPLANTS, DEVICES AND OBJECTS MAY BE HAZARDOUS TO YOU AND MAY INTERFERE WITH MRI PROCEDURE. PLEASE REMOVE ALL METALLIC OBJECTS, INCLUDING CREDIT CARDS.

CONSULT MRI PERSONNEL IF YOU HAVE ANY CONCERNS/QUESTIONS BEFORE ENTERING THE MRI ROOM.