MRI SCREENING FORM

Name:_____ Date:_____ Weight:_____ DOB:_____

****Remove ALL piercings in affected area, watches, hearing aids, hair pieces and pins****

Please check all the following:

( ) Yes ( ) No Cardiac Pacemaker or Wires

( ) Yes ( ) No Brain Aneurysm Clips

( ) Yes ( ) No Cochlear Ear Implants

( ) Yes ( ) No Pregnant

( ) Yes ( ) No Internal Defibrillator/Bone Growth Stimulator/Neurotransmitter

( ) Yes ( ) No Heart Valve/Stents/Coils/Filters

( ) Yes ( ) No Insulin Pump/Drug Infusion Pump

( ) Yes ( ) No Shunts: When? _____ Type:_____

( ) Yes ( ) No Joint Replacement/Pins/Rods/Mesh When?_____ Type:_____

( ) Yes ( ) No Retinal Tec Implant/Eye Prosthesis

( ) Yes ( ) No Penile Implant/Bladder Stimulator

( ) Yes ( ) No Skin/Drug Patch with Foil Backing

( ) Yes ( ) No Have you had any metal/shrapnel injury to your eyes/body

( ) Yes ( ) No Do you have removable metal dental appliances

LIST ALL SURGERIES:

_____

_____

_____

CONTRAST ONLY

( ) Yes ( ) No Are you Breastfeeding?

( ) Yes ( ) No Do you have Kidney Disease or Renal Failure?

( ) Yes ( ) No Do you have Sickle Cell Anemia?

( ) Yes ( ) No Do you have any allergies to any medications? If yes, please list:_____

_____

Patient Signature_____ Date_____

Technologist Signature_____Date_____