NYC HEALTH+ HOSPITALS

KINGS COUNTY HOSPITAL CENTER
Diagnostic Imaging
MRI Patient Information Record

Department of Radiology
Tel: 718-245-5584/5
Fax: 718-245-8651

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	☐	☐		
2. Cerebral aneurysm clips	☐	☐		
3. Ear Implants	☐	☐		
4. Spinal cord stimulator	☐	☐		
5. Implanted infusion pump	☐	☐		

	YES	NO		YES	NO		YES	NO
Brain Clips	☐	☐	Metal Mesh	☐	☐	Shrapnel	☐	☐
Aortic Clips	☐	☐	Metal tracheotomy	☐	☐	Hairpins/Hairclips	☐	☐
Heart Valves	☐	☐	Penile implants	☐	☐	Permanent eyeliner	☐	☐
IVC filter(umbrella)	☐	☐	IUD	☐	☐	Tattoos	☐	☐
Shunts	☐	☐	Denture	☐	☐	Cardiac Stents	☐	☐
Joint Replacement	☐	☐	Hearing Aid	☐	☐	Are you a metal worker?	☐	☐
Limb prosthesis	☐	☐	Electrodes	☐	☐	Metal in the eyes?	☐	☐
Rods or Screws	☐	☐	Bullet Fragments	☐	☐	Any other metal	☐	☐

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.