

*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                       |                          |                          |                          |                         |                          |                          |
| 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: \_\_\_\_\_

Interpreter 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.**