

(MRI) screening form for MR.I visitors /Patient next of kin

NAME: -----

JOB TITLE: -----

AGE: -----

ADDRESS: -----

- Have you had prior surgery or an operation (e.g. arthroscopy, endoscopy, etc) of any kind? No Yes
If yes please indicate the date and type of surgery: Type of surgery: _____
- Have you experienced any problem related to previous MRI examination or MR procedure? No Yes
If yes please describe: _____
- Have you ever been injured to the eye involving a metallic object or fragment (e.g. metallic silvers, shavings, foreign body, etc.)? No Yes
If yes please describe: _____
- Have you ever been injured by a metallic object or foreign body (bullet, shrapnel, etc.)? No Yes
If yes please describe: _____
- Do you have any other relevant clinical history? No Yes
If yes please describe: _____

For females:

- Are you pregnant or might be pregnant? No Yes

**WARNING:
DO NOT ENTER**

The MR system magnet is always on

- Please indicate if you have any of the following: (please ✓)

<input type="checkbox"/>	Aneurysm clips	<input type="checkbox"/>	Implanted drug infusion device	<input type="checkbox"/>	Any metallic fragment or foreign body
<input type="checkbox"/>	Cardiac pacemaker	<input type="checkbox"/>	Artificial or prosthetic limb	<input type="checkbox"/>	Wire mesh implant
<input type="checkbox"/>	Implanted cardioverter defibrillator (ICD)	<input type="checkbox"/>	Metallic stent, filter, or coil	<input type="checkbox"/>	Tissue expander (e.g., breast)
<input type="checkbox"/>	Electronic implant or device	<input type="checkbox"/>	Shunt (spinal or intraventricular)	<input type="checkbox"/>	Surgical staples, clips, or metallic sutures
<input type="checkbox"/>	Magnetically-activated implant or device	<input type="checkbox"/>	Vascular access port and/or catheter	<input type="checkbox"/>	Joint replacement (hip, knee, etc.)
<input type="checkbox"/>	Neurostimulation	<input type="checkbox"/>	Radiation seeds or implants	<input type="checkbox"/>	Any type of prosthesis (eye, penile, etc.)
<input type="checkbox"/>	Spinal cord stimulator	<input type="checkbox"/>	Swan-Ganz or thermodilution catheter	<input type="checkbox"/>	Heart valve prosthesis
<input type="checkbox"/>	Internal cord or wires	<input type="checkbox"/>	Body piercing jewelry	<input type="checkbox"/>	Bone/joint pin, screw, nail, wire, plate, etc.
<input type="checkbox"/>	Bone growth/bone fusion stimulator	<input type="checkbox"/>	Hearing aid	<input type="checkbox"/>	Tattoo or permanent makeup
<input type="checkbox"/>	Cochlear, otologic, or other ear implant	<input type="checkbox"/>	Medication patch (Nicotine, Nitroglycerine)	<input type="checkbox"/>	Insulin or other infusion pump

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Visitor/patient next of kin Signature: _____

Date ____/____/____

Form completed by: _____

Date ____/____/____

Form Information Reviewed by: _____

Date ____/____/____

