



Department of Radiology

Patient Identification

MRI Patient Screening Form

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the Magnetic Resonance exam (i.e., MRI, MR angiography, functional MRI MR Spectroscopy). DO NOT ENTER the MR system scan room or MR environment if you have any question or concern regarding an implant, device, or metal. Consult the MRI Technologist or Radiologist BEFORE entering the MR system scan room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- Pacemaker / Pacer wires / breast expander / Implanted cardioverter defibrillator (ICD)
 - Yes No Don't Know
- Intracranial or brain aneurysm clip
 - Yes No Don't Know
- Electronic brain/spinal cord stimulator
 - Yes No Don't Know

IF YES, TO ANY QUESTION STOP HERE AND CONTACT A MEMBER OF THE RADIOLOGY DEPARTMENT

Weight: _____ Height: _____

Female patients only: Yes No

Are you pregnant or do you think you may be pregnant?		
Are you currently breastfeeding?		
First day of last menstrual period:	/	/

All patients please answer/check the following:

Check the Following	Yes	No
Neurostimulation System		
Any type of prosthesis (eye, limb, penile, etc.)		
Bone growth/bone fusion stimulator		
Heart valve prosthesis		
Cochlear, otologic, or other ear implant		
Hearing aid (remove prior to entering)		
Eye injury involving a metallic object or fragment		
Injury involving a metallic object (bullet or shrapnel, etc)		
Eyelid spring or wire		
Body piercing jewelry		
Tattoos / permanent makeup		
Vascular access port and/or catheter		
Swan-Ganz or Thermodilution catheter		
Medication patch (nicotine, nitroglycerin)		
Any metallic fragment or foreign body		
Tissue expander (e.g. breast)		
Surgical staples, clips, metallic sutures or stents		
Bone/joint pin, screw, nail, wire, plate, etc. joint replacement artificial limb etc.		
Radiation seeds or implants		
Other implant/metal or device		
IUD or diaphragm		
Kidney disease		
Dialysis		
Liver or kidney transplant		
Claustrophobia		

Patient or Guardian Signature: _____ **Date:** _____

This section is to be filled out by RADIOLOGY STAFF:

	Yes	No
Orbital Images		
Disposition of Valuables (locker / family member)		

MRI Technologist Name: _____ **Time:** _____

MRI Technologist Signature: _____ **Date:** _____