

**WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI. The MR system magnet is ALWAYS on. It is very important you inform the MRI staff about anything that has been placed inside your body, even if you have previously been scanned in MRI.**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

What is the reason for your MRI today \_\_\_\_\_

Please indicate if you have any of the following:

• Pacemaker / Pacer wires / Implanted cardioverter defibrillator (ICD)  
 YES  NO

• Intracranial or brain aneurysm clip or coils  
 YES  NO

• Electronic stimulator of any kind (Brain, VNS, DBS, Bone, Spine, Bladder, Bowel)  
 YES  NO

If YES, WHAT KIND OF STIMULATOR \_\_\_\_\_

• Do you have Stents or a Programmable Shunt?  
 YES  NO

If Yes, explain \_\_\_\_\_

• Tissue Expander (BREAST OR OTHER AREA)  
 YES  NO

• Liver or Kidney transplant or bypass or other organ transplant  
 YES  NO

If YES, WHAT KIND OF TRANSPLANT? \_\_\_\_\_

• Are you on DIALYSIS for your kidneys?  
 YES  NO

If Yes, when is your next dialysis appointment? Date: \_\_\_\_\_

• Do you have any information about your Implant?  
 YES  NO

If Yes, explain \_\_\_\_\_

**Check the Following**

**Yes No**

Cochlear, otologic, or other ear implant		
Any type of prosthesis (eye, limb, penile, etc.)		
Heart valve prosthesis/replacement		
Eyelid spring or wire		
Injury involving a metallic object (bullet or shrapnel, etc)		
Vascular access port and/or catheter		
Radiation seeds or implants		
Swan-Ganz or Thermodilution catheter		
Medication patch (nicotine, nitroglycerin, or any other type)		
Any metallic fragment or foreign body		
Surgical staples, clips, or metallic sutures		
Bone/joint pin, screw, nail, wire, plate, etc. joint replacement, artificial limb etc.		
IUD or diaphragm		
Tattoo or permanent makeup		
Body piercing jewelry		
Hearing aid (remove prior to entering MRI room)		
Other implant/metal or device		
Eye injury involving a metallic object or fragment		
Injury involving a metallic object		

**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:            /            /		

**Patient or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

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