beach cities orthopedics & sports medicine

MRI SAFETY SCREENING QUESTIONNAIRE

Name: _____ **Date:** _____

The following items may be harmful to you during your MRI scan or may interfere with the MR exam. Please provide a "yes" or "no" answer for every item.

YES	NO	
___	___	Cardiac **pacemaker** or implanted cardioverter defibrillator/ICD
___	___	Internal electrodes or wires (pacing wires, DBS or VNS wires)
___	___	Artificial heart valve, coil, filter and/or stent
___	___	Aneurysm clip(s)
___	___	Neurostimulator-TENSUnit, biostimulator, bone growth stimulator, DBS, VNS
___	___	Implanted drug pump (for chemotherapy medicine, pain medicine)
___	___	External drug pump (for insulin or other medicine)
___	___	IVaccessport(Port-a-Cath,Broviac,PICCline Swan-Gantz, Thermodilution)
___	___	Implanted post-surgical hardware (pins, rods, screws, plates, wires)
___	___	Ear (cochlear) implant, middle ear implant
___	___	**Hearing aid**
___	___	False teeth/dentures, metallic removable dental work, braces, retainers
___	___	Any type of implant held in place by a magnet
___	___	Injured by a metal object (bullet) and required medical attention
___	___	Medication patch (nitroglycerine, nicotine, contraceptive, estrogen)
___	___	Shunt or Sophy adjustable and programmable pressure valve
___	___	Spinal fixation device, spinal fusion and/or halo vest, spinal cord stimulator
___	___	Surgical clips, staples or surgical mesh
___	___	Tissue expander (breast)
___	___	Penile implant
___	___	Pessary, IUD, Diaphragm
___	___	Radiation Seeds (cancer treatment)
___	___	Body piercing, tattoo or permanent makeup
___	___	Wig, hair implants
___	___	Artificial joint and/or limb
___	___	Artificial eye and/or eyelid spring
___	___	Eye injury from a metal object (metal shavings, metal slivers)
		If **YES**, did you seek medical attention? **Y** **N**

Do you have a history of:

___	___	Claustrophobia
___	___	Cancer If so, what type of cancer? _____
___	___	Allergic reaction to MRI contrast

Female Patients: Are you pregnant? **YES** **NO**

If you are still menstruating, please provide the date of your last period:_____

If you answered YES to any of the questions, please discuss any concerns with your MR technologist.

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MRI CLINICAL INFORMATION

What symptoms or problems brought you to the doctor that resulted in this exam being ordered?

_____
_____
_____

Please list previous surgeries, including type(s) and date(s):

DATE	TYPE OF SURGERY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Instructions for the Patient, Parent, or Guardian:

- You are urged to use the ear plugs or headphones that we supply for use during your MRI examination since some patients may find the noise level unacceptable, and the noise levels may affect your hearing.
- **REMOVE:**
  - **ALL jewelry, body piercings, and hair pins/accessories**
  - **Hearing aids and eyeglasses**
  - **Watch, cell phone, credit/bank cards, or any other cards with a magnetic strip**
- Use gown if provided, or remove all clothing with metal fasteners, zippers, etc.

I attest that the above information is correct to the best of my knowledge. I have read and understood the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient Signature: _____ **Date**_____

MR Tech signature: _____