Patient Name: ______________________ DOB: ____________ Sex: ☐ M ☐ F XR#: ______________

MR#: __________ Procedure: ________________ Weight: _________ (lbs)

Technologist Name *(please print)*

These questions are designed to assist us in determining if it is safe for you to have a Magnetic Resonance Imaging (MRI) procedure. It is important for you to answer all of the following questions. If you do not understand any question, please ask for assistance. **A technologist will review the questions with you after you are done.**

Medical Implants/Devices – *Please Indicate if you have the following:*

	Yes	No	Do Not Know
Neurostimulator			
Spinal cord stimulator			
Bone growth stimulator			
Hearing aid			
Artificial Eye			
Dentures			
Aneurysm Clips			
An artificial or prosthetic limb			
Pacemaker, wires, defibrillator or implanted heart valve			
Any type of wire mesh implant			
Any other type of implant (i.e. Penile)			
Spinal Fusion procedure			
Cochlear implant with prosthesis			
A shunt (spinal or intra-ventricular)			
Radiation seeds or implants			
LINX magnetic esophageal band			
Tissue expanders			
Insulin pump			
Temperature sensing urinary catheter			
Metal pin, plate, joint, screw/nails or metallic object in or attached to your body (including bullets or shrapnel)			
IV Access Port (e.g. Broviac, Hickman, Port-a-Cath, PICC line)			

If you answered yes to any implant/device listed above, please provide the following information:

Date Implanted: **Make and Model of Implant:**

Facility: **Surgeon:**

A copy of the patient's implant device card has been obtained and scanned/sent to:

_______ PACS _______ Medical Records/HIM

General MRI Safety Questions – *Please Indicate if you have the following:*	Yes	No	Do Not Know
Are you currently wearing a wig/hair extensions or hair implants?			
Are you currently wearing Bobby Pins or Hair Accessories (barrettes, clips, etc)?			
Are you currently wearing non-prescription, color-tinted contact lenses or magnetically applied lashes?			
Are you currently wearing a Halo vest?			
Are you currently wearing a blood glucose monitoring or medication delivery system? (examples include – Neulasta OnPro System, FreeStyle Libre, V-Go, etc.)			
Do you have or have you had tattoos, tattooed eyeliner, lipliner, or body piercing?			
Do you wear a transdermal patch (i.e. nitroglycerin, nicotine, pain, birth control, etc)?			
Do you have an IUD, diaphragm, or pessary?			
Do you have any type of surgically implanted metal (i.e. surgical staples) of any type in your body?			
Do you work with metal or have you been exposed to metal fragments that could be in your eyes or body?			
Do you have any type of electronic or magnetically-activated device (i.e. stimulator or pump) in your body?			
Do you have a metallic stent, filter, or coil?			

Patient Label

Medical History/Allergies			
	Yes	No	Do not know
Have you had previous surgeries?			
Are you currently breastfeeding?			
Do you have an allergy to latex?			
Do you have a history of anemia?			
Do you have a history of blood disease?			
Do you have a history of asthma, emphysema, or other breathing disorders?			
Have you ever had a reaction to a contrast agent or x-ray dye used for MRI, CT, or X-Ray?			
Do you have diabetes?			
Do you have a history of seizures?			
Do you have sickle cell disease?			
Do you have multiple myeloma?			
Are you currently on ferumoxytol (Feraheme)?			
Have you had a joint injection in the past seven (7) days in the area to be scanned?			
Do you have a history of kidney problems (kidney disease, kidney failure, dialysis, any type of renal impairment, etc.)?			
Do you have high blood pressure?			
List all medications you are currently taking:			
List all surgeries you have had:			
List all known drug or food allergies:			

I have answered the questions above to the best of my knowledge.

Patient or Authorized Representative Signature	Patient or Authorized Representative Print Name	Date/Time
Technologist Signature		Date/Time

Patient Identification and Procedure Verification:

☐ Patient positively identified using two unique identifiers: ______________________ Technologist initials

☐ Written order for procedure matches exam requisition: ______________________ Technologist initials

Patient Label