Department of Radiology
Patient MR Safety Screening Form

Patient Name:____Date of Birth___/___/____Age:________________

MRN:_______________Height:______________Weight:_________Allergies:_______________________________________

Do you have any of the following items in or on your body?

☐Yes ☐No Aneurysm clip or coil
☐Yes ☐No Cardiac pacemaker, pacer wires, or implanted cardioverter defibrillator (ICD)
☐Yes ☐No Neurostimulator (e.g. brain, spine, bone)
☐Yes ☐No Hearing aid, eye or ear implants, springs or wires (e.g. cochlear implant)
☐Yes ☐No Tissue expanders (e.g. breast)
☐Yes ☐No Metallic stent, filter, coil or heart valve
☐Yes ☐No Magnetically activated implant or programmable device (e.g. VP shunt)
☐Yes ☐No Shunt (e.g. spinal, brain or intraventricular)
☐Yes ☐No Insulin or other infusion pump
☐Yes ☐No Joint replacement or any type of prosthesis (including pins, screws, nails)
☐Yes ☐No Swan Ganz catheter
☐Yes ☐No Surgical staples, clips, or metallic sutures
☐Yes ☐No Dental plate (s)
☐Yes ☐No Medication patch (e.g. Nicotine, Fentanyl, Nitroglycerine)
☐Yes ☐No Penile implant or pump
☐Yes ☐No Body piercing, tattoos, or any other metallic fragment or foreign body

Do any of the following apply to you?

☐Yes ☐No Have you had an injury to the eye involving a metallic object or fragment?
☐Yes ☐No Have you ever been injured by a metallic object (e.g. bullet, shrapnel)?
☐Yes ☐No Do you have any breathing problems or claustrophobia?

For Female Patients:

☐Yes ☐No Are you pregnant or suspect that you might be?
☐Yes ☐No Are you breast-feeding?
☐Yes ☐No Do you have an IUD?

Please complete the following, if your exam is ordered with contrast:

☐Yes ☐No Have you had an allergic reaction to iodinated or gadolinium contrast or a severe reaction to any allergen?
☐Yes ☐No Do you have an acute renal failure or injury?
☐Yes ☐No Are you currently on hemodialysis or peritoneal dialysis
☐Yes ☐No Do you have a condition called Nephrogenic Systemic Fibrosis (NSF)?

Comments:____

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 MRI procedure I am about to undergo.

Patient or Legal Guardian Name (Print)	Patient or Legal Guardian Name (Sign)	Date/Time
Reviewed By (Print)	Reviewed By (Sign)	Date/Time