**Department of Radiology**

**Patient MR Safety Screening Form**

**Patient Name**:Click or tap here to enter text.**Date of Birth** Click or tap to enter a date. **Age**:Click or tap here to enter text.

**MRN**Click or tap here to enter text.**Height:** Click or tap here to enter text. **Weight**: Click or tap here to enter text.

**Allergie**sClick or tap here to enter text.

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? Type?Click or tap here to enter text.

 [ ] YES [ ] NO Body piercing, tattoos, metallic fragments or foreign body.

[ ] **YES** [ ] **NO** **Magnetic cosmetics (e.g. eyelash extensions, nail polish, hair extensions**)

[ ] 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 Are you wearing contact lenses? Type?Click or tap here to enter text.

[ ] YES [ ] NO 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’S NAME: Click or tap here to enter text. DATE/TIME:Click or tap here to enter text.

REVIEWED BY: Click or tap here to enter text. DATE/TIME:Click or tap here to enter text.