

**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.