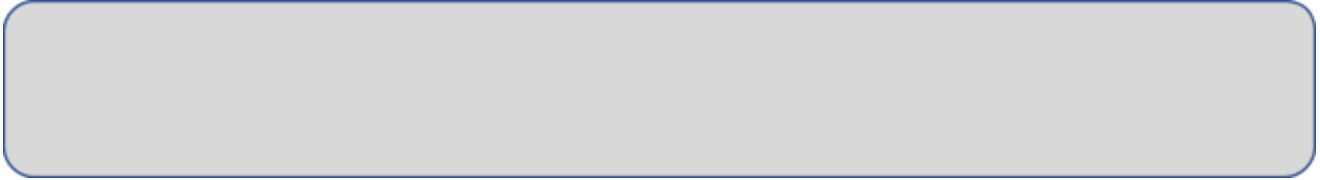


MRI Safety Screening Form

Patient Name _____ DOB _____ Age _____

Height _____ Weight _____ Referring Dr/NP _____



**Before entering MRI Environment or room please remove all
metallic objects including hearing aids, partials, key, cell phones,
jewelry, hair pins, glasses, watches, pocket knives, wallets, etc...**

Pacemaker/Defibrillator YES NO

Aneurysm Clips YES NO

Artificial Heart Valves YES NO

Heart or Other stents YES NO

Shunt/Filter/Coils YES NO

Spine Stimulator YES NO

Heart Monitors YES NO

Penile Implants/Pumps YES NO

**If YES to any above please provide date
implanted _____**

Diabetes YES NO

Infusion/Drug Pump YES NO

Mesh Implant YES NO

Joint Replacement YES NO

Rods, Screws, Plates YES NO

Cochlear Implant YES NO

Surgical Clips/Staples YES NO

Metallic Foreign Body YES NO

(Gun Shot Wound, BB, Shrapnel)

Metal Shavings in Eyes YES NO

Prior Eye/Ear surgery YES NO

Prior Brain Surgery YES NO

Other Metallic Implants YES NO

**If YES to any above please provide date
implanted _____**

Pregnant YES NO

Epilepsy/Seizures YES NO

Uncooperative YES NO

Claustrophobic YES NO

Unable to hold still YES NO

Tissue Expander(Breast) YES NO

Dentures/Partials YES NO

Pain Patches YES NO

Tattoos YES NO

IUD/Birth Control YES NO

Hearing Aids YES NO

List Medical **Symptoms** related to todays exam _____

List **ALL Surgeries** _____

X _____

Patients Signature

Date

X _____

Tech Signature

