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