SMIL
SOUTHWEST MEDICAL IMAGING
AFFILIATED WITH RADIOLOGY PARTNERS

MRI SAFETY FORM

All metal must be removed prior to your MRI Examination. This includes: keys, hairpins, barrettes, jewelry, body piercings, watch, pocket knife, safety pins, wigs, dentures, hearing aids, etc. You will be asked to remove your street clothes and put on a gown. A locker with a key is provided to lock up your clothes and valuables.

LIST ALL SURGERIES AND APPROXIMATELY WHEN IT WAS PERFORMED

• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____

FOR SAFETY AND OPTIMAL IMAGE QUALITY, PLEASE ANSWER IF YOU HAVE OR HAVE HAD THE FOLLOWING

☐ YES ☐ NO Prior problems with MRI
- Please describe_____

☐ YES ☐ NO Been notified of an implant you have, that has been recalled
☐ YES ☐ NO Brain aneurysm clip
☐ YES ☐ NO Shunt (spinal or intraventricular)
☐ YES ☐ NO Eyelid spring
☐ YES ☐ NO Injury from metal (shavings, slivers) in eye
Did you seek medical attentions ☐ YES ☐ NO
☐ YES ☐ NO Cochlear or any other ear implant
- Type/date implanted _____

☐ YES ☐ NO Heart valve prosthesis
☐ YES ☐ NO Cardiac pacemaker
☐ YES ☐ NO Implanted cardiac defibrillator
☐ YES ☐ NO Heart monitor/Loop recorder
- Type/date implanted _____

☐ YES ☐ NO Swan-Ganz Catheter
☐ YES ☐ NO Stimulator (Neuro, spinal, vagus, sacral, phrenic, bladder, bone growth, deep brain)
- Type/location _____

☐ YES ☐ NO Internal electrodes or wires
☐ YES ☐ NO Any stent, filter or coil
- Type/location _____

☐ YES ☐ NO Implanted drug infusion device or Vascular access port or catheter (Hickman, Port-a-Cath)
☐ YES ☐ NO Insulin pump or other external infusion pump
☐ YES ☐ NO Glucose monitor (remove)
☐ YES ☐ NO Electronic or magnet implant or device
☐ YES ☐ NO Anything held in place by a Magnet
☐ YES ☐ NO Any injuries with metal objects/foreign bodies? (BB, bullet, shrapnel, shavings, fragments)
- Type/location _____

☐ YES ☐ NO Tissue expander (e.g. breast)
☐ YES ☐ NO Joint replacements (hip, knee, etc.)
☐ YES ☐ NO Artificial or prosthetic limb
☐ YES ☐ NO Prosthesis (eye, penile, etc.)
☐ YES ☐ NO Spinal fusion or fixation
☐ YES ☐ NO Bone/Joint pins, screw, nail, wire, plates etc.
☐ YES ☐ NO Surgical staples, clips
☐ YES ☐ NO Surgical mesh implant
☐ YES ☐ NO Metal clips in stomach for bleeding
☐ YES ☐ NO Tattoo or permanent makeup
☐ YES ☐ NO Wig, toupee or hair extensions
☐ YES ☐ NO Medications patches
☐ YES ☐ NO Currently pregnant or breastfeeding
☐ YES ☐ NO Dialysis or history of renal (kidney) disease
☐ YES ☐ NO IUD, diaphragm, pessary
☐ YES ☐ NO Body piercing (remove)
☐ YES ☐ NO Hearing aid (remove)
☐ YES ☐ NO Dentures, partial plates (remove)
☐ YES ☐ NO Any other implants

Name: _____ Signature: _____Date: _____
Person completing the form ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Patient Name: _____ DOB: _____ Weight: _____ Height: _____

MRI Safety Form evaluated prior to the XR (tech initials) _____

OFFICE USE ONLY

ACC: _____

MR Technologist Signature _____ Date:_____