

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 APPROXIMATE DATE IT WAS PERFORMED

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

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

<input type="checkbox"/> YES <input type="checkbox"/> NO Prior problems with MRI	<input type="checkbox"/> YES <input type="checkbox"/> NO Insulin pump or other external infusion pump
• Please describe _____	<input type="checkbox"/> YES <input type="checkbox"/> NO Glucose monitor (remove)
<input type="checkbox"/> YES <input type="checkbox"/> NO Do you have an implant that you were notified it had been recalled	<input type="checkbox"/> YES <input type="checkbox"/> NO Electronic or magnet implant or device
<input type="checkbox"/> YES <input type="checkbox"/> NO Brain aneurysm clip	<input type="checkbox"/> YES <input type="checkbox"/> NO Anything held in place by a Magnet
<input type="checkbox"/> YES <input type="checkbox"/> NO Shunt (spinal or intraventricular)	<input type="checkbox"/> YES <input type="checkbox"/> NO Any injuries with metal objects/foreign bodies? (BB, bullet, shrapnel, shaving, fragments)
<input type="checkbox"/> YES <input type="checkbox"/> NO Eyelid spring or other implant _____	• Type/location _____
<input type="checkbox"/> YES <input type="checkbox"/> NO Injury from metal (shavings, slivers) in eye	<input type="checkbox"/> YES <input type="checkbox"/> NO Tissue expander (e.g. breast)
Did you seek medial attention? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO Joint replacements (hip, knee, etc.)
<input type="checkbox"/> YES <input type="checkbox"/> NO Cochlear or any other ear implant	<input type="checkbox"/> YES <input type="checkbox"/> NO Artificial or prosthetic limb
• Type/date implanted _____	<input type="checkbox"/> YES <input type="checkbox"/> NO Prosthesis (eye, penile, etc.)
<input type="checkbox"/> YES <input type="checkbox"/> NO Heart valve prosthesis	<input type="checkbox"/> YES <input type="checkbox"/> NO Spinal fusion or fixation
<input type="checkbox"/> YES <input type="checkbox"/> NO Cardiac pacemaker	<input type="checkbox"/> YES <input type="checkbox"/> NO Bone/Joint pins, screw, nail, wire, plates etc.
<input type="checkbox"/> YES <input type="checkbox"/> NO Implanted cardiac defibrillator	<input type="checkbox"/> YES <input type="checkbox"/> NO Surgical staples, clips
<input type="checkbox"/> YES <input type="checkbox"/> NO Heart monitor/Loop recorder	<input type="checkbox"/> YES <input type="checkbox"/> NO Surgical mesh implant
• Type/date implanted _____	<input type="checkbox"/> YES <input type="checkbox"/> NO Metal clips in stomach for bleeding
<input type="checkbox"/> YES <input type="checkbox"/> NO Swan-Ganz Catheter	<input type="checkbox"/> YES <input type="checkbox"/> NO Tattoo or permanent makeup
<input type="checkbox"/> YES <input type="checkbox"/> NO Stimulator (Neuro, spinal, vagus, sacral, phrenic, bladder, bone growth, deep brain)	<input type="checkbox"/> YES <input type="checkbox"/> NO Wig, toupee or hair extensions
• Type/location _____	<input type="checkbox"/> YES <input type="checkbox"/> NO Medications patches
<input type="checkbox"/> YES <input type="checkbox"/> NO Internal electrodes or wires	<input type="checkbox"/> YES <input type="checkbox"/> NO Currently pregnant or breastfeeding
<input type="checkbox"/> YES <input type="checkbox"/> NO Any stent, filter or coil	<input type="checkbox"/> YES <input type="checkbox"/> NO History of Dialysis or Current Dialysis
• Type/location _____	<input type="checkbox"/> YES <input type="checkbox"/> NO IUD, diaphragm, pessary
<input type="checkbox"/> YES <input type="checkbox"/> NO Implanted drug infusion device or Vascular access port or catheter (Hickman, Port-a-Cath)	<input type="checkbox"/> YES <input type="checkbox"/> NO Body piercing (remove)
<input type="checkbox"/> YES <input type="checkbox"/> NO Magnetic eyelashes/eyeliner	<input type="checkbox"/> YES <input type="checkbox"/> NO Hearing aid (remove)
	<input type="checkbox"/> YES <input type="checkbox"/> NO Dentures, partial plates (remove)
	<input type="checkbox"/> YES <input type="checkbox"/> NO Any other implants

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

Name of person completing the form if other than patient: _____ Spouse Parent Other: _____

Signature: _____ Date: _____

MRI Safety form evaluated prior to the XR (tech initials) _____	OFFICE USE ONLY	PID # _____
MRI Technologist Signature: _____		Date: _____