Rev 02/12/2016

MRI SAFETY & SCREENING FORM

TECH FORM

NAME:_____M/F_____DOB_____/_____/_____WEIGHT_____

PLEASE ANSWER THE FOLLOWING QUESTIONS CAREFULLY: Circle YES or NO

Have you had a previous MRI of any kind? YES NO If yes, date/year ?_____
Have you ever been a machinist, welder, or sheet metal worker? YES NO
Have you ever been hit in the face or **eye** with a **piece of metal** (BB, shavings, filings)? YES NO
Ever had a piece of metal removed from your eye? YES NO Eye implants? YES NO
Have you ever had any type of **surgical procedure** (operation)? YES NO
If Yes, what kind and when? _____

Please circle any of the following items that may be in body:

YES NO **PACEMAKER OR DEFIBRILATOR**
YES NO **Spinal Cord Stimulator** or Neuro Stimulator of any kind [Tens Unit]
YES NO **Cardiac Stents** [Heart] _____Patch of any type _____Artificial Heart Valve
YES NO **ANEURYSM** [Clip, Coil, or Stent] of any kind [Brain, Aorta, Carotid, Artery]
If so, where in the body?_____
YES NO **STENT** in any part of the body? [Carotid Artery/Neck, Legs, or Arms]
YES NO Ear implants of any kind _____Hearing aids (Internal or External)
YES NO Electrical stimulator for Nerves or Bones _____Coil or filter of any type
YES NO Orthopedic hardware of any kind [screws, pins, plates, or rods]
YES NO Any implant of any kind? If so, what? _____
YES NO SHUNT of any type _____Penile Prosthesis
YES NO Prosthesis of any type. If so, where _____
YES NO Drug/ Insulin Pump _____Internal _____External (can be removed)
YES NO Metal to any part of the body (including bullet, bb, shavings, filings, & Shrapnel metals)

- The following items may be damaged or pose a threat to anyone in the magnetic suite.

These items need to be removed prior to entering the magnet room.

•Dentures or Partials •Jewelry •Watch •Credit Cards •Safety pins
•Bobby pins or hairpins •Wigs or hairpieces •Drug Patches

FOR FEMALE PATIENTS
Any chance of you being **PREGNANT**? YES NO Are you breast feeding? YES NO

I attest that the answers I have given on this form are true and correct to the best of my knowledge. Open MRI of SANPC is not responsible for any valuables or objects brought into this facility. I have read this form and understand its contents. I have been given the opportunity to ask questions and have had those questions answered to my satisfaction.

Patient Name [PRINT] _____ **Date**_____

Signature of patient or guardian _____

FOR OFFICE USE ONLY! PLEASE DO NOT FILL OUT BELOW THIS BOX.

☐ **PROCEDE WITH SCAN** **Initials:**_____ ☐ **DO NOT PROCEDE WITH SCAN**

Technologist Signature _____Print name_____

Nurse Signature ONLY _____Print Name_____

Pre-Screening Form
Appointments for MRI Scans

Patient Name:_____Date:_____

- Pacemaker / Defibrilator **YES NO**
- Heart Surgery / STENT **YES NO**
- Brain Surgery / Aneurysm Surgery **YES NO**
- Stents - ANY **YES NO**
- Hearing Implant / Ear Surgery **YES NO**
- Metal Implants **YES NO**
- Stimulator Implants **YES NO**
- Eye Surgery / Implant **YES NO**
- Metal to eyes (Any experience of metal grinding) **YES NO**
- Metal to any part of body (bullet, BB, shavings, filings) **YES NO**

- Claustrophobic **YES NO**
- Pregnant **YES NO**
- Currently taking any blood thinners **YES NO**
(i.e. Plavix, aspirin, coumadin, etc…)
- If **none of the above,** please initial stating all questions above were answered with **NO**. Initials _____

Patient signature _____Print_____

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SANPC NURSE signature_____Print_____

☐ **PROCEDE WITH SCHEDULING**

☐ **DO NOT PROCEDE WITH SCHEDULING**

Initials:_____

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