



For Office Use Only  
 ID No.:

**MAGNETIC RESONANCE IMAGING SCREENING FORM**

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Male Female  
 Last name First name Middle Initial

Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Phone (H) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Cell) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

1. Have you ever had major surgery? No Yes  
 If yes, please specify type of surgery: \_\_\_\_\_  
 If yes, is any metal object left in your body after the surgery? No Yes
2. Have you experienced any problem related to a previous MRI examination or MR procedure? No Yes  
 If yes, please describe: \_\_\_\_\_
3. Have you ever been injured by a metallic object or fragment (e.g., BB, bullet, shrapnel, metallic slivers, shavings, etc.)? No Yes  
 If yes, please describe: \_\_\_\_\_
4. Are you pregnant, possible pregnant or breast feeding? No Yes N/A

The MRI room contains a very strong magnet. Some metal objects can interfere with your scan or even be dangerous. Before you are allowed to enter, we must know if you have any metal in your body or have experienced any of the conditions listed below. Please circle the correct answer from each of the following:

- |   |   |
|---|---|
| Yes No Aneurysm clip(s)                           | Yes No Shunt (spinal or intraventricular)                       |
| Yes No Cardiac pacemaker                          | Yes No Vascular access port and/or catheter                     |
| Yes No Implanted cardioverter defibrillator (ICD) | Yes No Radiation seeds or implants                              |
| Yes No Electronic implant or device               | Yes No Swan-Ganz or thermodilution catheter                     |
| Yes No Magnetically-activated implant or device   | Yes No Medication patch (Nicotine, Nitroglycerine)              |
| Yes No Neurostimulation system                    | Yes No Metallic fragment or foreign body in eyes                |
| Yes No Spinal cord stimulator                     | Yes No Surgical staples, clips, or metallic sutures             |
| Yes No Internal electrodes or wires               | Yes No Joint replacement (hip, knee, etc.)                      |
| Yes No Bone growth/bone fusion stimulator         | Yes No Bone/joint pin, screw, nail, wire, plate, etc.           |
| Yes No Cochlear, otologic, or other ear implant   | Yes No IUD, diaphragm, or pessary                               |
| Yes No Insulin or other infusion pump             | Yes No Dentures, partial plates or permanent retainer           |
| Yes No Implanted drug infusion device             | Yes No Tattoo or permanent makeup acquired within 6 wks or less |
| Yes No Any type of prosthesis (eye, penile, etc.) | Yes No Body piercing jewelry                                    |
| Yes No Heart valve replacement                    | Yes No Hearing aid  |
| Yes No Eyelid spring or wire                      | Yes No Magnetic Eyeliner/Eyelashes                              |
| Yes No Artificial or prosthetic limb              |   |
| Yes No Stent, filter, or coil                     |   |

Please remove all metallic objects before MR examination including: keys, hair pins, barrettes, jewelry, watch, safety-pins, paperclips money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material. Ear protection is required during the MRI examination.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and had the opportunity to ask questions regarding the information on this form.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date \_\_\_\_\_