

MAGNETIC RESONANCE IMAGING (MRI) SCREENING FORM (pg2)



The MRI system magnet is ALWAYS on.

Do not enter the MR Scan room until you have reviewed this section for devices or implants that may be hazardous or may interfere with the MR procedure.

Please indicate if you have any of the following:

Aortic Aneurysm (AAA) Grafts	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cardiac Pacemaker	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Pacing Wires or pacemaker that has been removed	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Implanted Cardioverter Defibrillator (ICD)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Swan-Ganz or thermodilution catheter	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Heart valve Replacement	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any type of electronic, mechanical or magnetic implant type:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Brain Aneurysm clip or coil type: _____ Date Implanted: _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
VNS - Vagal Nerve Stimulator	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Eyelid spring or wire	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Permanent or tattooed eyeliner, mascara or other cosmetic	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cochlear, otologic or other ear implant	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hearing Aid	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Wig or hair implants	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Dentures, Braces or Partial Plate	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Neurostimulator (for spinal or back pain)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Spinal fixation device	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Implanted drug pump (e.g., insulin, Baclofen, chemotherapy)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Shunt (spinal or intraventricular)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any type of internal electrodes or wires	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Joint Replacement (e.g., hip, knee)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Bone growth or fusion stimulator	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Pins, rods, screws, nails, plates or wires	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Filters, coils or stents (for blood clots) type: _____ Date Implanted: _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any IV access port (e.g., Port-a-Cath, Hickman, PICC line)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Tissue expander (e.g., Breast)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Surgical (wire) mesh implant	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Medication Patch (e.g., nicotine, nitroglycerine, pain medicine)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Penile implant or prosthesis type: _____ Date Implanted: _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
At this time do you have an IUD, Diaphragm or pessary?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
A tattoo or body piercing jewelry anywhere on your body	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any other type of implant type: _____ Date Implanted: _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Date: / /

Authorized Signature(patient/family member or guardian or RN if done by phone)

MRI Technologist reviewing this form:

(signature of person bringing patient into the scan room)