MRI SAFETY SCREENING

Because of the strong magnetic field and the potential for use of a contrast agent (dye), we must have an accurate medical and surgical history. **Please answer the questions below.**

- ❑ Yes ❑ No Cardiac pacemaker or defibrillator- now/before
- ❑ Yes ❑ No Valves, stents or filters
- ❑ Yes ❑ No Cochlear (ear) implant
- ❑ Yes ❑ No Aneurysm or aortic clip
- ❑ Yes ❑ No Pumps (implanted or external)
- ❑ Yes ❑ No Neurostimulator (spine/brain/vagus nerve)
- ❑ Yes ❑ No VP shunt
- ❑ Yes ❑ No Shrapnel/bullet fragments
- ❑ Yes ❑ No Metal fragment exposure to your eyes
- ❑ Yes ❑ No IUD
- ❑ Yes ❑ No Dialysis
- ❑ Yes ❑ No Prior reactions to MRI or CT contrast (dye)
- ❑ Yes ❑ No Penile implant

IF "YES" OR YOU ARE UNSURE ABOUT ANY OF THE ABOVE QUESTIONS, PLEASE TELL THE FRONT DESK STAFF IMMEDIATELY.

- ❑ Yes ❑ No Artificial limbs/joint replacement
- ❑ Yes ❑ No Harrington rods
- ❑ Yes ❑ No Metal/pins/screws in your body
- ❑ Yes ❑ No Wire sutures
- ❑ Yes ❑ No Surgery in the last 6 weeks
- ❑ Yes ❑ No Renal (kidney) disease
- ❑ Yes ❑ No Congestive heart failure
- ❑ Yes ❑ No Currently taking IV antibiotic therapy
- ❑ Yes ❑ No Medication patches
- ❑ Yes ❑ No Tattoo/cosmetic tattoo
- ❑ Yes ❑ No Body piercing
- ❑ Yes ❑ No Removable dental work
- ❑ Yes ❑ No Hearing aid
- ❑ Yes ❑ No Multiple Myeloma
- ❑ Yes ❑ No Diabetes
- ❑ Yes ❑ No Are you taking hydroxyurea?
- ❑ Yes ❑ No Are you on chemotherapy?
  If yes, list medications: ____________________
- ❑ Yes ❑ No Do you have any allergies, including medications?
  If yes, list allergies: ____________________

Signature of patient: ____________________ Date: ____________

Name of the person filling out this form, if other than the patient (please print): ____________________

Relationship to the patient (please print): ____________________

Technologist Initials: ________

Affix Pt Sticker Here

(9/15)