

Radia

Because of the presence of a strong magnetic field, it is important that we are aware of any metallic objects that have been surgically placed or otherwise introduced into your body. Therefore, an accurate surgical and medical history is needed. Please answer the questions below, providing a Yes or No for every item. Please indicate if you have or have had any of the following: (To be completed by anyone entering the MRI suite)

- | YES | NO | |
|-----|-----|---|
| ___ | ___ | Any injury to your eye from a metal object (metal slivers, metal shavings, other metal object)? |
| ___ | ___ | Any electronic, mechanical, or magnetic implant. (Type_____) |
| ___ | ___ | Cardiac pacemaker |
| ___ | ___ | Aneurysm/Aortic Clips |
| ___ | ___ | Implanted cardiac defibrillator |
| ___ | ___ | Neurostimulator or Biostimulator (Type_____) |
| ___ | ___ | Any type of internal electrodes or wires |
| ___ | ___ | Cochlear (ear) implant |
| ___ | ___ | Hearing aid |
| ___ | ___ | Implanted drug pump (e.g., insulin, chemotherapy, pain medicine) |
| ___ | ___ | Spinal fixation device/fusion procedure |
| ___ | ___ | Any type of coil, filter, or stent (Type_____) |
| ___ | ___ | Any type of metal object (e.g., shrapnel, bullet, BB) |
| ___ | ___ | Artificial heart valve |
| ___ | ___ | Penile implant |
| ___ | ___ | Any type of implant held in place by a magnet (Type_____) |
| ___ | ___ | Any type of surgical clip or staple |
| ___ | ___ | Any I.V. access port (e.g., Broviac, Port-a-Cath, Hickman, Picc line) |
| ___ | ___ | Medication patch (e.g., Nitroglycerine, nicotine) |
| ___ | ___ | Shunt |
| ___ | ___ | Artificial limb or joint (What and where_____) |
| ___ | ___ | Removable dentures, false teeth, or partial plate |
| ___ | ___ | Body piercing (Location_____) |
| ___ | ___ | Wig, hair implants |
| ___ | ___ | Tattoos or tattooed eyeliner |
| ___ | ___ | Radiation seeds (e.g., cancer treatment) |
| ___ | ___ | Any implanted items (e.g., pins, rods, screws, nails, plates, wires) |

I attest that the above information is correct to the best of my knowledge.

Signed: _____ **Date:** _____
Signature of patient or legal decision maker

Relationship to Patient: _____

Pt Name: _____

DOB: _____ **MRN#:** _____