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| **Safety Screening Form for** **Magnetic Resonance (MR) Procedures** |
| Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name (First, Middle, Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender: □Male □Female Age \_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Height: \_\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_  |

**If uncertain of any answer, please circle and leave blank to discuss with the technologist.**

Yes shrapnel)

No Injury by a metal object or foreign body (e.g., bullet, BB,

If yes, explain:

Yes No Injury to your eye from a metal object

Yes No If yes, did you seek medical assistance?

If yes, describe what was found:

Yes No Foreign body removed from eye

If yes, describe what was taken out:

Yes No Spinal fusion procedure

Yes No Endoscopy or colonoscopy in last 30 days

**The following items may be harmful to you during your MR scan and may interfere with the MR exam.**

# Please indicate if you CURRENTLY HAVE or HAVE EVER HAD any of the following:

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| **Surgically implanted medical devices** |

* □ Yes □ No Any type of electronic, mechanical or magnetic implant

 If yes, list type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* □ Yes □ No Cardiac pacemaker, defibrillator, or other cardiac implant (in place or removed)
* □ Yes □ No Aneurysm Clip
* □ Yes □ No Neurostimulator, diaphragmatic stimulator, deep brain stimulator, vagus nerve stimulator, bone growth stimulator, spinal cord stimulator, or any biostimulator (in-place or removed)

 If yes, list type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* □ Yes □ No Any type of internal electrodes or wires
* □ Yes □ No Cochlear implant
* □ Yes □ No Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)
* □ Yes □ No Spinal fixation device
* □ Yes □ No Any type of coil, filter, or stent

 If yes, list type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* □ Yes □ No Artificial heart valve
* □ Yes □ No Any type of ear implant
* □ Yes □ No Artificial eye

• □ Yes □ No Penile implant

* □ Yes □ No Eyelid spring and/or eyelid weight
* □ Yes □ No Any type of implant held in place by a magnet
* □ Yes □ No Any type of surgical clip or staple
* □ Yes □ No Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, PICC line)
* □ Yes □ No Shunt

 If yes, type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* □ Yes □ No Tissue Expander (e.g., breast)
* □ Yes □ No IUD

 If yes, type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* □ Yes □ No Surgical mesh

 If yes, location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* □ Yes □ No Radiation seeds
* □ Yes □ No Any implanted items (e.g., pins, rods, screws, nails, plates, wires)

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| **Removable medical devices** |

* □ Yes □ No Hearing aid
* □ Yes □ No Removable drug pump (e.g., insulin, Baclofen, Neulasta)
* □ Yes □ No Any type of ear implant
* □ Yes □ No Artificial eye
* □ Yes □ No Any type of implant held in place by a magnet
* □ Yes □ No Artificial limb

If yes, what and where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* □ Yes □ No Medication patch (e.g., nitroglycerine, nicotine)
* □ Yes □ No Removable dentures, false teeth or partial plate
* □ Yes □ No Diaphragm, pessary

If yes, type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* □ Yes □ No Have you recently ingested a “pill cam?”

If yes, date “pill cam” was ingested? \_\_\_\_\_\_\_\_\_\_\_

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| **Personal** |

* □ Yes □ No Body piercings
* □ Yes □ No Wig, hair implants
* □ Yes □ No Tattoos or tattooed liner
* □ Yes □ No Any hair accessories (e.g., bobby pins, barrettes, clips, extensions, weaves)
* □ Yes □ No Jewelry
* □ Yes □ No Metal-containing clothing material and/or underwear
* □ Yes □ No Magnetic cosmetics and hair care (e.g., magnetic eyelashes, magnetic nail polish)
* □ Yes □ No Electronic monitoring or tagging equipment (e.g., ankle monitor)
* □ Yes □ No Fitness tracker/bio monitor (e.g., Fitbit)
* □ Yes □ No Any other type of surgically implanted devices, removable medical devices or personal items not covered above?

If yes, type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have read and understand the entire content of this form.**

Patient signature:

MD/RN/RT signature: \_