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 thetechnologist.

- ☐ Yes ☐ No Injury by a metal object or foreign body (e.g., bullet, BB, shrapnel)
- If yes, explain:
- ☐ Yes ☐ No Injury to your eye from a metal object
- ☐ Yes ☐ No If yes, did you seek medical assistance?

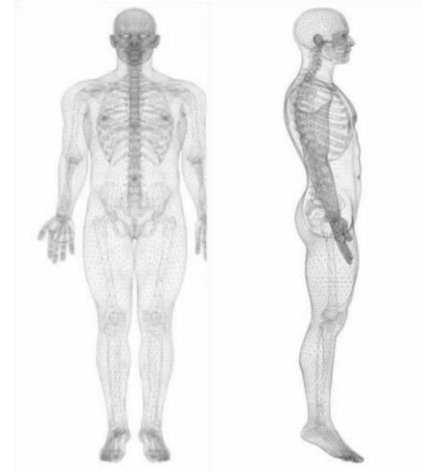
  If yes, describe what was found:
- ☐ Yes ☐ No Foreign body removed from eye

  If yes, describe what was taken out: ________________________________
- ☐ Yes ☐ No Spinal fusion procedure
- ☐ Yes ☐ No Endoscopy or colonoscopy in last 30 days

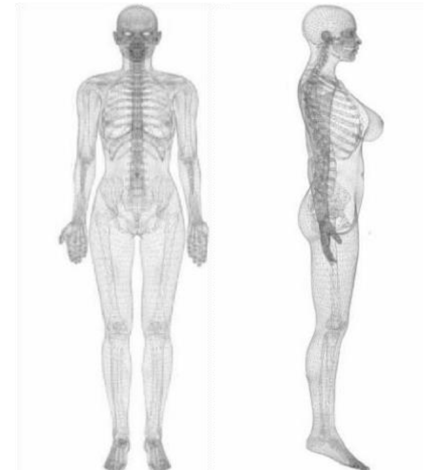
MR Hazard Checklist

Please mark the location of any implant, device or metallic foreign body inside your body or site of surgical operation.

Male:



Female:



Reference/Source: Kanal's MagnetVision™ app, 2020.

The following items may be harmful to you during your MR scan and may interfere with the MR exam.
You must provide a "YES" or "NO" answer every time.

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

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)

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? ___________

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: ____