

METAL PRE-SCREENING FORM

Name _____ Date _____ Weight _____

MRI uses a very powerful magnet, which can disturb certain metallic objects or implants in the body. To insure your safety, we ask that you very carefully complete the following screening questions. If you have any questions, or need assistance completing this form, please see an MRI Staff Member.

Please mark Yes or No to indicate if you have any of the following:

Yes No

* _____ Have you EVER sought medical treatment due to an object that may have been metal striking the eye(s)? (Example: from grinding, welding, drilling, shrapnel, etc.)

* If yes, please specify if object was removed or if your eye exam, by a physician, was negative. Removed _____ Negative Exam _____ Not removed/ Unknown _____

- _____ Cardiac Pacemaker or Pacer Wires
_____ Aneurysm Surgery(s): If YES where? _____
_____ Implanted Cardiac Defibrillator, Cardioverter, or Holter Monitor
_____ Vagal Nerve Stimulator (Brain Pacemaker)
_____ Biostimulator, Neurostimulator (TENS unit), Bone Growth Stimulator
_____ Are you Claustrophobic or are you bothered by small places?
_____ Implanted Medication or Insulin Pump
_____ Medication Patches such as Nitroglycerin, birth control, or nicotine (these items must be removed)
_____ Heart Valves, Shunt, Programmable Valve on Shunt, Coils, Filters, Stent, Zenith Graft for Abdominal Aortic Aneurysm
_____ Any implanted Metal Rods, Plates, Pins, Screws, Nails, Wire Mesh, or Clips from surgery
_____ Artificial Joint or Limb Replacement
_____ Shrapnel, BuckShot, Bullets, or BB's still in your body
_____ Eye Surgery or Artificial Eye Implant
_____ Ear Surgery or Ear Implant (Cochlear or Stapes Implant)
_____ Hearing Aid
_____ Dentures, Braces or any Removable Dental Ware
_____ Bravo or M2A procedure in last 30 days
_____ Any Hair pins/clips, Wigs, Hair pieces
_____ Any type of Electrical, Mechanical, or Magnetic implant not mentioned, Please list
_____ Permanent Eyeliner*, Tattoos*, or Body Piercing [*A SMALL PERCENTAGE OF PATIENTS WITH TATTOOS HAVE EXPERIENCED TRANSIENT SKIN IRRITATION IN ASSOCIATION WITH MRI. THEREFORE YOU MAY WANT TO DECIDE IF THIS SLIGHT RISK WARRANTS UNDERGOING YOUR EXAMINATION AND DISCUSS THIS WITH YOUR REFERRING PHYSICIAN].
_____ Do you have a history (current or previous) of ANY of the following: Renal (Kidney) Disease or Insufficiency; Kidney Transplant; Liver Transplant; Hepato-Renal Syndrome?

For Male Patients

For Female Patients

- _____ Penile Implant
_____ IUD, Diaphragm or Pessary?
_____ Are you pregnant or do you suspect that you are pregnant?

For Inpatients (In Critical Care Setting)

- _____ Swan-Ganz Catheter
_____ Temperature Probe

I have answered these questions to the best of my ability and I understand that possible injury could be a result of my withholding vital information.

Signature of Patient/Guardian _____ Date _____

Office Use Only:

MD/RN/RT/Coordinator signature preliminary screening patient: _____

FORM MUST BE SIGNED BY A TECHNOLOGIST BEFORE PATIENT CAN ENTER THE SCAN ROOM

Signature of Technologist Approving Patient entry into scanner: _____

Name of Scanning Technologist: _____