

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, or 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 or any Removable Dental Ware

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].

Are you diabetic, have renal insufficiency or on dialysis?

For Inpatient (In Critical Care Setting)

Swan-Ganz Catheter

For Male Patients

Penile Implant

For Female Patients

IUD, Diaphragm or Pessary?

Are you pregnant or do you suspect that you are pregnant?

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

Name of Technologist Approving Patient entry into scanner: _____

Name of Scanning Technologist: _____