

# MRI SAFETY SCREENING

Patient Name: \_\_\_\_\_ Patient date of birth: \_\_\_\_\_

Allergies \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**Any surgery in the last 2 weeks** .....yes.....no  
if yes, what kind? \_\_\_\_\_

**Have you ever had any of the following surgeries/implants:**

Implanted Neurological Stimulator.....	yes.....no.....don't know
Pacemaker or pacemaker wires.....	yes.....no.....don't know
Open heart surgery.....	yes.....no.....don't know
Artificial heart valve before 1984.....	yes.....no.....don't know
Brain surgery.....	yes.....no.....don't know
Aneurysm surgery.....	yes.....no.....don't know
Middle ear implant.....	yes.....no.....don't know
Cataract surgery/eye lens implant.....	yes.....no.....don't know
Any implanted mechanical/electrical device.....	yes.....no.....don't know
Artificial limb or joint.....	yes.....no.....don't know
Metal tracheostomy.....	yes.....no.....don't know
Other surgeries? If yes, what kind _____	

Have you ever been a machinist, welder or metal worker?..... yes.....no

Have you ever had a piece of metal flushed/removed from your eye?..... .yes.....no

**Do you have any of the following items in your body (circle them)?**

Bullets/BBs/pellets	wires/plates/screws	IUD
dental implants	Shrapnel	stents
penile prosthesis	middle ear implant	metal fragments
infusion pump	hearing aid	hairpins
surgical clips	screws	false teeth/retainers
breast implants	pins/pacemaker wires	coils
braces	blood clot filter	transdermal patch

Do you have a tattoo, permanent make-up or body piercing?..... yes.....no

Can you stand without assistance?..... yes.....no

Are you claustrophobic?..... yes.....no

Are you physically impaired?..... yes.....no

Do you have uncontrollable shaking?..... yes.....no

Are you currently using a Broviac, Swan-Ganz catheter or oxygen? .....yes.....no

Can you lie still on your back for 1 hour?..... yes.....no.....don't know

Are you pregnant?..... yes.....no.....not SURE

**Please sign below  
(patient / parent or guardian)**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Approved: \_\_\_\_\_

Type of implants/surgeries/foreign body:

Approved by:

Date: