PRE-MRI SAFETY SCREENING

Name:				Referring Physician:	
D.O.B:	Sex:	Height:	Weight:	Date:	MRN#

Technologist Notes: _____

_____

Please indicate if you have any of the following:

- ☐ YES ☐ NO **Aneurysm clip(s)**
- ☐ YES ☐ NO **Cardiac pacemaker**
- ☐ YES ☐ NO **Implanted cardiac defibrillator (ICD)**
- ☐ YES ☐ NO **Magnetically-activated implant or device**
- ☐ YES ☐ NO **Electronic implant or device**
- ☐ YES ☐ NO **Neurostimulation system**
- ☐ YES ☐ NO **Spinal cord stimulator**
- ☐ YES ☐ NO **Internal electrodes or wires**
- ☐ YES ☐ NO **Bone growth/bone fusion stimulator**
- ☐ YES ☐ NO **Cochlear or other ear implant**
- ☐ YES ☐ NO **Insulin or other infusion pump**
- ☐ YES ☐ NO **Implanted drug infusion device**
- ☐ YES ☐ NO **Any type of prosthesis (eye, penile, etc.)**
- ☐ YES ☐ NO **Heart valve prosthesis**
- ☐ YES ☐ NO **Eyelid spring, wire, or artificial eye**
- ☐ YES ☐ NO **Artificial or prosthetic limb**
- ☐ YES ☐ NO **Metallic stent filter or coil**
- ☐ YES ☐ NO **Shunt (spinal or intraventricular)**
- ☐ YES ☐ NO **Vascular access port and/or catheter**
- ☐ YES ☐ NO **Radiation seeds or implants**
- ☐ YES ☐ NO **Any metallic fragment or foreign (BB, bullet, shrapnel)**
- ☐ YES ☐ NO **Wire mesh implant**
- ☐ YES ☐ NO **Tissue expander (e.g. breast)**
- ☐ YES ☐ NO **Surgical staples, clips, or metallic sutures**
- ☐ YES ☐ NO **Joint replacement (hip, knee, etc.)**
- ☐ YES ☐ NO **Bone/joint pin, screw, nail, wire, plate, etc.)**
- ☐ YES ☐ NO **IUD, diaphragm, or ring**
- ☐ YES ☐ NO **Dentures or partial plates**
- ☐ YES ☐ NO **Tattoo or permanent makeup**
- ☐ YES ☐ NO **Body piercing jewelry**
- ☐ YES ☐ NO **Wig or hair implant**
- ☐ YES ☐ NO **Have you ever been a welder, grinder or sheet metal worker?**
- ☐ YES ☐ NO **Have you ever had an injury involving a metallic object or fragment?**
- ☐ YES ☐ NO **Hair accessories?**
- ☐ YES ☐ NO **Hearing aid (Remove before entering MRI)**
- ☐ YES ☐ NO **Other implant**
- ☐ YES ☐ NO **Medication patch**

Diagnostic Imaging Center of Terrebonne
a TGMC affiliate

Health History:

- ☐ YES ☐ NO **Claustrophobia**
- ☐ YES ☐ NO **Cancer (If yes, type/treatment)**

_____

_____

- ☐ YES ☐ NO **Drug allergies (If yes, describe)**

_____

_____

- ☐ YES ☐ NO **Pregnant, or think you may be?**

Date of last menstrual period: _____

- ☐ YES ☐ NO **Breast feeding**
- ☐ YES ☐ NO **Kidney disease**
- ☐ YES ☐ NO **Are you on Dialysis?**
- ☐ YES ☐ NO **Injury related to today's exam?**

Date of injury: _____

☐ **Work or** ☐ **MVA**

- ☐ YES ☐ NO **Any surgery in the last 6 weeks?**
- ☐ YES ☐ NO **Have you had any surgery on the part of your body being examined today?**

If so, when? _____

List all prior surgical procedures: _____

_____

_____

_____

_____

Describe why you are having this exam done today? _____

_____

_____

_____

_____

Technologist Signature:	Date:	Time:
Patient Signature:	Date:	Time: