MRI SCREENING FORM

Today's Date: _____

Name: _____ Sex: **M** *or* **F** Weight: _____ Height: _____

Date of Birth: _____

Why did your doctor order this test for you today? _____

Please describe any pain you are having currently. _____

Do you have, or have you ever had any of the following?	**YES**	**NO**
Cardiac Pacemaker		
Heart Surgery/ Heart Valve: If yes, explain:		
Implanted Cardiac Defibrillator (ICD), Pacer Wires?		
Brain Aneurysm Clip/ Brain Surgery: If yes, explain:		
Shunts/ Stents/ Filters/ Intravascular Coil		
Eye Surgery/ Implants/Springs/ Wires/ Retinal Tack		
Injury to the eye involving Metal or Metal Shavings		
Orthopedic Pins/ Screws/ Rods/ Joints/ Prosthesis		
Neurostimulator / Biostimulator		
History of Cancer or Tumors/ Implanted Radiation Seeds		
Previous Back Surgery (Lumbar/ Thoracic/ Cervical): When: Where:		
Ear Surgery/ Cochlear Implants/ Hearing Aids/ Stapes Prosthesis		
Vascular Access Port/ Catheter		
Metal Mesh Implants/ Wire Sutures/ Wire Staples or Clips/ Internal Electrodes		
Electrical/ Mechanical/ Magnetic Implants/ Penile Implant		
Implanted Drug Infusion Pump/ Insulin Pump		
Body Piercings/Tattoos? If yes, where:		
Any type of medicated adhesive patches?		
Dentures/ Partials/ Dental Implants		
Gunshot Wounds/ Shrapnel		
Are you pregnant or is there a chance that you may be pregnant?		
Are you currently breastfeeding?		

I attest that the information provided is correct to the best of my knowledge. I have read and understand the contents of this form and I have had the opportunity to ask questions regarding the information on this form. I understand if I provided false information regarding any metal injury and/ or implants, I am held responsible for any injury or risk that may be involved with having an MRI.

X _____ Date: _____

Patient/Parent/Legal Guardian

X _____ Date: _____

Technologist Signature