

MRI Screening Questionnaire

Name _____	MRN _____
DOB _____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____ Height _____ Weight _____

Have you had an MRI before? Did you have any complications with the MRI? Have you ever had an allergic reaction to MRI contrast? Have you had a prior injury by a metal object to any body part? Was the metal object medically removed?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	Comments _____ _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
Please circle any personal items and implants you may have: Screws/Plates/Pins Spinal Rods/Hardware	Hair pins/wig* Piercings* Loop recorder Artificial joint Eye Implant		
Are you currently on dialysis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Please mark any of the following items/implants you currently have:

<input type="checkbox"/> Hearing aid* <input type="checkbox"/> Medication patch* <input type="checkbox"/> Insulin pump* <input type="checkbox"/> Continuous Glucose Monitor* <input type="checkbox"/> Pacemaker or Defibrillator <input type="checkbox"/> Stimulator (e.g. DBS, VNS, SCS, bladder) <input type="checkbox"/> Pain or baclofen pump <input type="checkbox"/> Ear/cochlear implants <input type="checkbox"/> Tissue expanders (doesn't include breast implants) <input type="checkbox"/> Programmable shunt	<input type="checkbox"/> IV access port <input type="checkbox"/> Aneurysm clips <input type="checkbox"/> Coils <input type="checkbox"/> Filters <input type="checkbox"/> Stents (other than heart) <input type="checkbox"/> IUD <input type="checkbox"/> Penile implant <input type="checkbox"/> NONE add'l info: _____
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***These items must be removed prior to your MRI to prevent damage to the item and/or harm to you.**

I acknowledge that I will remove these items prior to my MRI.

Signature of Patient/Guardian/Relative/Clinical Service

X _____ Date _____ Time ____:____

If patient/family member unavailable, requesting staff shall sign above & document in the paper/digital chart that no family member is available; above screening was completed by the requesting service. Based upon reasonable review, the benefits of the MRI exam outweigh the risks.

Reviewed by Radiology MD/RN/RT _____ Printed Name _____ Date _____ Time ____:____