ADI
Advanced Diagnostic Imaging
A branch of CVMS

SAFETY SCREENING FORM FOR MAGNETIC RESONANCE (MR) PROCEDURES

Date_____ Name (First, Middle, Last) _____

Female [ ] Male [ ] Age_____ Date of Birth _____ Height _____ Weight_____

Why are you having this examination (medical problem)?

_____

_____

	YES	NO
Have you ever had an MRI examination before? If yes, please describe _____	____	____
Have you ever had Cancer? If so, what type_____	____	____
Have you ever been injured by a metal object or foreign body (e.g., bullet, BB, shrapnel)? If yes, please describe _____	____	____
Have you ever had an injury from a metal object in your eye (metal slivers, metal shavings, other metal object)?	____	____
If yes, did you seek medical attention?	____	____
If yes, describe what was found? _____		
Do you have a history of kidney disease, diabetic, asthma, or other allergic respiratory disease?	____	____
Have you ever received a contrast agent or X-ray dye used for MRI, CT, or other X-ray or study?	____	____
Have you ever had an X-ray dye or magnetic resonance imaging (MRI) contrast agent allergic reaction? If yes, please describe _____	____	____
Are you diabetic?	____	____
If so, do you wear a Continual glucose monitor?	____	____

Are you pregnant, suspect you may be pregnant, or are breast feeding? (Please circle which)

MR HAZARD CHECKLIST

Please indicate if you have had any of the following:

YES	NO	
____	____	Any type of electronic, mechanical, or magnetic implant Type _____
____	____	Cardiac pacemaker
____	____	Aneurysm clip
____	____	Implanted cardiac defibrillator
____	____	Neurostimulator
____	____	Biostimulator Type _____
____	____	Any type of internal electrodes or wires
____	____	Cochlear implant
____	____	Hearing aid

OVER →

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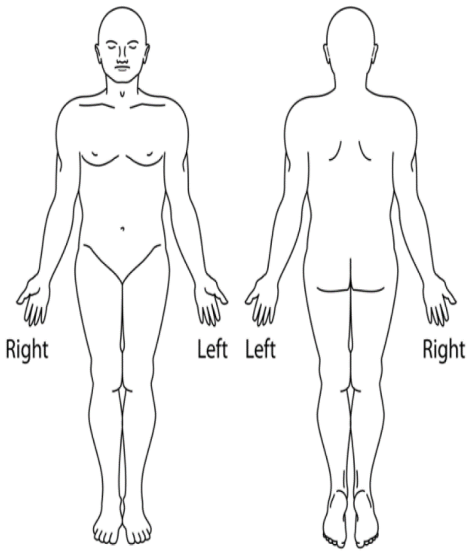
YES	NO	
____	____	Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)
____	____	Halo vest
____	____	Spinal fixation device
____	____	Spinal fusion procedure
____	____	Any type of coil, filter, or stent Type _____
____	____	Any type of metal object (e.g., shrapnel, bullet, BB)
____	____	Artificial heart valve
____	____	Any type of ear implant
____	____	Penile implant
____	____	Artificial eye
____	____	Eyelid spring
____	____	Any type of implant held in place by a magnet Type _____
____	____	Any type of surgical clip or staple
____	____	Any IV access port (a.g., Broviac, Port-a-Cath, Hickman, Picc line)
____	____	Medication patch (e.g., Nitroglycerine, nicotine)
____	____	Shunt
____	____	Artificial limb or joint What and where _____
____	____	Tissue Expander (e.g., breast)
____	____	Removable dentures, false teeth or partial plate
____	____	Diaphragm, IUD, Pessary Type _____
____	____	Surgical mesh Location _____
____	____	Body piercing Location _____
____	____	Wig, hair implants
____	____	Tattoos or tattooed eyeliner
____	____	Radiation seeds (e.g., cancer treatment)
____	____	Any implanted items (e.g., pins, rods, screws, nails, plates, wires)
____	____	Any hair accessories (e.g., bobby pins, barrettes, clips)
____	____	Jewelry
____	____	Any other type of implanted item Type _____



Please mark where you have had surgery/metal objects

Instructions for the Patients

1. You are urged to use the ear plugs or headphones that were supply for use during your MRI examination since some patients may find the noise levels unacceptable, and the noise levels may affect your hearing.
2. Remove all jewelry (e.g., necklaces, pins, rings)
3. Remove all hair pins, bobby pins, barrettes, clips, etc.
4. Remove all dentures, false teeth, partial dental plates
5. Remove hearing aides
6. Remove eyeglasses
7. Remove your watch, pager, cell phone, credit and bank cards and all other cards with a magnetic strip.
8. Remove body piercing objects
9. Use gown, if provided, or remove all clothing with metal fasteners, zippers, etc.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form, and I have had the opportunity to ask questions regarding the information on this form.

Patient signature _____

MD/RN/RT signature _____ Date_____

Print name of MD, RN, RT _____