

MRI Safety Screening Sheet



Patient Name _____ **Age** _____ **Weight** _____

Please check yes or no if you have any of the following:

- | Y | N | | Y | N | |
|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Removable dentures/Dental work |
| <input type="checkbox"/> | <input type="checkbox"/> | Epicardial defibrillator | <input type="checkbox"/> | <input type="checkbox"/> | Magnetically Held Dentures |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain Aneurysm Clip | <input type="checkbox"/> | <input type="checkbox"/> | Coil, filter, wire, or stent in a blood vessel |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Aneurysm Clip | <input type="checkbox"/> | <input type="checkbox"/> | Implanted pump |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Valve replacement | <input type="checkbox"/> | <input type="checkbox"/> | Neurostimulator |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Stent | <input type="checkbox"/> | <input type="checkbox"/> | IUD, pessary, diaphragm |
| <input type="checkbox"/> | <input type="checkbox"/> | Nitroglycerin patch (Depoint) | <input type="checkbox"/> | <input type="checkbox"/> | Penile implant |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing aid | <input type="checkbox"/> | <input type="checkbox"/> | Hardware (pins, screws, wires, rods, plates) |
| <input type="checkbox"/> | <input type="checkbox"/> | Cochlear Sussman ear implant | <input type="checkbox"/> | <input type="checkbox"/> | Tatoed eyeliner |

Please list **all surgeries**:

Please list **all allergies**:

Y N

- | | | |
|--------------------------|--------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Did you ever work with sheet metal? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there ANY chance you have metal fragments in your eyes or facial area? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a gunshot wound from a bullet, BB, schrapnel, or pellet? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there any chance you are pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently breastfeeding? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any blood diseases, Hemolytic Anemia, or Sickle Cell Anemia? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any problems with your kidneys, seizures, or asthma? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a reaction from the contrast used for CT, X-Ray, or MRI? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking birth control pills or receiving hormone treatment? |

Previous exams that pertain to today's exam (please state location, approx. dates, and body part that was scanned):

REMOVE all jewelry, credit cards, hearing aids, glasses, hair pins, safety pins, pens, and any other metallic objects before your MRI. Lockers will be provided for personal items. MRI is generally a safe procedure. Qualified personnel will explain the test. You will hear loud tapping, buzzing noises during the scan, earplugs will be given to you. MRI uses a strong magnetic field and CANNOT be done on patients with pacemakers, brain aneurysm clips, any metal in the eyes and certain implants. **Please inform technologist if you have any metal in your body before the scan.**

Please sign that you have read and understand the entire contents of this form:

Signature

Date

- ▶ MRI
- ▶ CT
- ▶ Ultrasound
- ▶ Bone Densitometry
- ▶ Breast MRI
- ▶ Digital Mammography

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