

**MRI PATIENT SCREENING**

Patient Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_

**CIRCLE CORRECT ANSWER – IF YOU ANSWER “YES” TO ANY OF THE QUESTIONS 1-5, PLEASE NOTIFY SOMEONE**

- 1. Yes            No            Do you have a pacemaker?
- 2. Yes            No            Have you ever had metal fragments in your eyes?
- 3. Yes            No            If “yes”, have they been removed? When? \_\_\_\_\_
- 4. Yes            No            Have you ever had brain surgery?
- 5. Yes            No            If yes, do you have brain clips?

**IF YOU ANSWERED YES TO ANY OF THE QUESTIONS 1-5, PLEASE NOTIFY SOMEONE BEFORE CONTINUING**

- 6. Yes            No            Do you have removable dental work?
- 7. Yes            No            Do you have asthma?
- 8. Yes            No            Are you claustrophobic?

**THE FOLLOWING ITEMS CAN INTERFERE WITH MRI IMAGING, AND SOME MAY JEOPARDIZE YOUR SAFETY. PLEASE INDICATE WITH A CHECK MARK IF YOU HAVE ANY OF THESE ITEMS IN YOUR BODY.**

- |       |                            |       |                                 |
|-------|----------------------------|-------|---------------------------------|
| _____ | Aortic Clips               | _____ | Joint Replacements              |
| _____ | Carotid Clips              | _____ | Bone or Joint Pins              |
| _____ | Heart Valve Replacement    | _____ | Prosthesis                      |
| _____ | Insulin Pump or Port       | _____ | Metal Mesh                      |
| _____ | Infusion Pump (Porta Cath) | _____ | Wire Sutures                    |
| _____ | Hearing Aids               | _____ | Shrapnel/BB’s/Buckshot          |
| _____ | Coclear Implant in Ear     | _____ | Any other metal or foreign body |
| _____ | Shunt in Brain             | _____ | Describe _____                  |
| _____ | Penile Implant             |       |                                 |

Yes            No            Have you had X-rays of area we are scanning today?  
If Yes, when? \_\_\_\_\_ Where? \_\_\_\_\_

Yes            No            Have you had a previous MRI of the area we are scanning today?  
Of Yes, when? \_\_\_\_\_ Where? \_\_\_\_\_

**Women Only**

Yes            No            Are you pregnant at this time?

Yes            No            Do you have an IUD? If yes, what kind? \_\_\_\_\_

This procedure will be explained to you and all your questions addressed prior to the MRI scan.

I do not have a pacemaker, nor have I had surgery requiring aneurysm clips. I do not have cochlear implants in the ear, nor do I have metallic foreign bodies in the eye. I am fully aware that if I have any of the above, an MRI scan could be hazardous to my health. The above questions have been answered truthfully, and I agree to the MRI study.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_