PATIENT IDENTIFIERS

☐ Inpatient: ☐ Name ☐ Medical Record Number

☐ Outpatient: ☐ Name ☐ Date of Birth: ____________

Patient Weight: ________ kg

Patient Height: ________ cm / inches
(please circle one)

Magnetic Resonance Imaging (MRI) is a diagnostic procedure used to image various organs and tissue inside the body. It operates with a radiofrequency pulse and a large magnet. No X-rays or radioactivity are involved. However, because of the high magnetic field, certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI procedure. Do not enter the MRI room or MRI environment if you have any question or concern regarding an implant, device, or object. ***Consult the MRI technologist BEFORE entering the MRI room. The MRI magnet is ALWAYS on.***

You will be requested to remove ALL metallic objects before entering the MRI room. This includes hearing aids, dentures, partial plates, keys, beepers, cell phones, eye glasses, hairpins/bobby pins, safety pins, watches, paperclips, money clips, credit cards/wallets, coins, pens, pocket knives, nail clippers, tools, clothing with metal fasteners, and clothing with metallic threads. Failure to do so may result in injury or damage to your property.

Do you have any of the following:	Yes	No
Cardiac (heart) pacemaker/defibrillator	☐	☐
If yes, model name and #: ____________________		
Artificial heart valve prosthesis	☐	☐
Aneurysm clip(s)	☐	☐
Implanted drug infusion device or pump (including insulin pumps)	☐	☐
Any type of neurostimulator (eg, DBS, VNS, Spinal or Bladder)	☐	☐
Any type of bone growth stimulator	☐	☐
Cochlear implants, inner ear prosthesis, or hearing aids	☐	☐
Any intravascular coils, filters, or stents	☐	☐
Shrapnel or bullet(s)	☐	☐
Permanently tattooed eyeliner	☐	☐
Removable dental work	☐	☐

Do you have any of the following:	Yes	No
Any type of shunts (eg, Spinal or Intraventricular) If yes, is it programmable? ☐ Yes ☐ No	☐	☐
Any other metallic implant or device(s) not listed? ____________________	☐	☐
Kidney disease	☐	☐
Drug Allergies – If yes, list drug allergies ____________________ ____________________ ____________________	☐	☐

Have you ever worked in a machine shop or similar environment where you may have been subjected to small, metal slivers which may have gone in your eyes and required medical attention? ☐ Yes ☐ No

Females Only:

Are you pregnant or do you suspect you may be pregnant? ☐ Yes ☐ No

Are you breast feeding? ☐ Yes ☐ No

I attest this information is correct to the best of my knowledge.

Signed: ______________________________ (patient) ____________________ (date)

Signed: ______________________________ (patient's representative) ____________________ (relationship)

Radiology Staff Use Only

X-rays of the head required? ☐ Yes ☐ No

Results of X-rays: ☐ Yes, MRI can be performed
☐ **No, MRI is contraindicated**

____
Radiologist's Name

MRI Staff – Name ____________________ **Date** ________ **Time** ________

Patient Name: Patient Identification #:

XR0002

MRI Screening Form
Department of Radiology

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