MRI – PRE EXAM SAFETY QUESTIONNAIRE

Patient: ______________________ Date of Birth: ______________ Appt. Date: ________

Ordering Physician: ____________________ Height: ________________ Weight: __________

Type of Exam: ________________________ Time of MRI: ________________ am/pm

PLEASE CHECK YES OR NO FOR ALL OF THE FOLLOWING:

	YES	NO
Previous MRI Exam	___	___
Metallic Prosthesis	___	___
Permanent Eyeliner/Tattoos/Piercing	___	___
Pregnancy	___	___
Nursing Mother	___	___
Aneurysm – Placement of Vascular Clips	___	___
Intracranial Bypass Graft Clips	___	___
Eye Orbital Prosthesis (Metal Shank to Anchor False Eye)	___	___
Metal Middle and Inner Ear Prosthesis (Wiring)	___	___
Cardiac Pacemaker or Wires	___	___
Cardiac – **Heart Valves or Stents**	___	___
Fresh Postoperative Persons with Metal Clips or Wires Implanted	___	___
Some Types of Implanted Devices with Metal (i.e. Ten's unit, Insulin Pump, Chemo Infusion Ports)	___	___
Bullets or Shrapnel	___	___
Metallic Fragments in eye (Have you been employed as a machinist, grinder, carpenter?)	___	___
Penile Implant	___	___
Contraceptive Uterine Device	___	___
Are you wearing a dermal patch of any kind? (i.e. morphine, nitropatch, pain patch, birth control)	___	___

I have read and understand the above questions asked.
I have had my questions and concerns answered and I consent to the MRI examination.

Signature: ____ Date: ____________

Signature of Parent/Guardian: ______________________________ Date: ____________

Witness: ____ Date: ____________

MRI Technologist: ____________________________________ Date: ____________