MDR
MAGNETIC DIAGNOSTIC RESOURCES OF CNY
THE MRI SPECIALISTS IN CNY SINCE 1985

MRI METAL SCREENING FORM

Patient name _____ DOB _____

Warning: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI Procedure. Do not enter the MR system room or MR Environment if you have any question or concern regarding an implant, device or object. Inform the MRI Technologist before entering the MRI system room. The MRI Scanner is ALWAYS ON!

THE FOLLOWING ITEMS MAY BE HARMFUL TO YOU DURING YOUR MR SCAN OR MAY INTERFERE WITH THE MR EXAMINATION. YOU MUST PROVIDE A "YES" OR "NO" FOR EVERY ITEM.

Yes ☐ No ☐ Have you had a surgery or procedure in your lifetime?
Please list below and give the date of the surgery.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Yes ☐ No ☐ Cardiac pacemaker or ever have a temporary one?
Yes ☐ No ☐ Implanted cardiac defibrillator?
Yes ☐ No ☐ Internal electrodes or retained pacemaker wires?
Yes ☐ No ☐ Artificial heart valve or heart prosthesis?
Yes ☐ No ☐ Stent, coil or filter? What part of body? _____
Yes ☐ No ☐ Aneurysm clip
Yes ☐ No ☐ Neurostimulator or biostimulator? (e.g. spinal,bladder etc.)
Yes ☐ No ☐ Eyelid springs, weights or wires?
Yes ☐ No ☐ Shunt? (Spinal or ventricular)
Yes ☐ No ☐ Cochlear implants, otologic, or other ear implants?
Yes ☐ No ☐ Ever been injured by any metallic foreign body? (Bullet, shrapnel, etc.)
Yes ☐ No ☐ Artificial limb or joint?
Yes ☐ No ☐ Surgical or wire mesh? Location? _____
Yes ☐ No ☐ Surgical clips or skin staples?
Yes ☐ No ☐ Diaphragm, IUD or pessary? Type: _____
Yes ☐ No ☐ Tissue expander? (Breast)
Yes ☐ No ☐ Tattoo(s)? Or permanent makeup location: _____
Yes ☐ No ☐ Radiation seeds or implants?
Yes ☐ No ☐ Any artificial prosthesis? (Eye, penile, heart etc.)
Yes ☐ No ☐ Medication patches? (All patches should be removed)
Yes ☐ No ☐ Swan ganz catheter or thermodialtion catheter?
Yes ☐ No ☐ Do you have any type of drug infusion device or insulin pump?
Yes ☐ No ☐ Any I.V. access port? (Port-a-cath, hickman, picc line)
Yes ☐ No ☐ Wound dressings impregnated with silver?
Yes ☐ No ☐ Jewelry or body piercings? Location(s) _____
Yes ☐ No ☐ Wigs, hairpieces, hair implants, bobby pins, barrettes ?
Yes ☐ No ☐ Hearing aid? (Please remove or aid can be damaged)
Yes ☐ No ☐ Dentures, partial plates or false teeth?
Yes ☐ No ☐ **Any electronic, mechanical or magnetic implants?**
Yes ☐ No ☐ **Ever had an eye injury with metallic slivers or shavings?**
Yes ☐ No ☐ Any implanted items?
Yes ☐ No ☐ Any type of implanted item not listed type: (Pins, rods, screws, nails, plates, wires) _____
Yes ☐ No ☐ Are you pregnant or suspect you are pregnant? (Consent required)

PRE-CONTRAST SCREENING QUESTIONS

Yes ☐ No ☐ Do you have any allergies?

If yes, list the allergy and what happens to you.

1. _____
2. _____
3. _____
4. _____

Yes ☐ No ☐ Have you ever experienced a severe allergic reaction to anything?
Yes ☐ No ☐ Have you ever had a reaction to a contrast medium used for MRI or CT?
Yes ☐ No ☐ Do you have a history of asthma, allergic respiratory disease or seizures?
Yes ☐ No ☐ Are you breast feeding?
Yes ☐ No ☐ Do you have high blood pressure? (hypertension)
Yes ☐ No ☐ Do you have a history of diabetes?
Yes ☐ No ☐ Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, liver (hepatic) disease?
If yes, please describe:

_____

_____

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 have had the opportunity to ask questions regarding the information on this form.

Patient Signature: _____ **Date**: _____ **Your Weight:** _____

If the patient is incapable of completing this form or is a minor (under 18 years of age), please document the persons name completing this form and their relationship to the patient.

Name: _____ Signature _____

Relationship to Patient: _____

HOSPITAL STAFF THAT COMPLETED SCREENING FORM WITH PATIENT

The above information has been reviewed and approved by me (MD / PA / NP / RN) prior to exam.

Name _____ Signature _____

Title _____ Date _____ Time _____

FOR TECHNOLOGIST USE ONLY

☐ Squeeze ball ☐ Earplugs ☐ Music ☐ Claustrophobic

Technologist Signature _____ Date _____ Time _____