Magnetic Resonance Imaging (MRI) questionnaire
Reason for MRI and/or Symptoms

__________________________________________________________

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MRI procedure. Do not enter the MRI scanner 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.

1. Patient Height _______ Patient Weight ______
2. Do you have a cardiac pacemaker or implanted cardiac defibrillator (ICD)? □ YES □ NO
3. Do you have a cerebral aneurysm clip (a clip on a blood vessel) in your brain? □ YES □ NO
4. Have you ever worked with, or been hit in the eye with a piece of metal? □ YES □ NO
   If YES, was it removed by a physician? □ YES □ NO If NO, is there a chance it is still there? □ YES □ NO
5. Are you pregnant, possibly pregnant? □ YES □ NO  First day of LMP: __________________________
6. Please list any prior surgery that you have had with the approximate dates:

__________________________________________________________

7. Do you have a shunt? □ YES □ NO  If YES, is it programmable? □ YES □ NO
8. Do you have any metal objects implanted inside your body? □ YES □ NO  If YES, please tell us what the object is and where it is located in your body.

9. Do you have any of the following items in/on your body?
   YES □ NO □
   □ Electronic implant or device
   □ Magnetically-activated implant or device
   □ Neurostimulation system
   □ Spinal cord stimulator
   □ Internal electrodes or wires
   □ Bone growth/bone fusion stimulator
   □ Cochlear, otologic or other ear implant
   □ Insulin or other infusion pump
   □ Glucose monitor
   □ Implanted drug infusion device
   □ Any type of prosthesis (eye, penile, etc.)
   □ Heart valve prosthesis
   □ Eyelid spring or wire
   □ Artificial or prosthetic limb
   □ Vascular Stent, filter or coil
   YES □ NO □
   □ Port a Cath
   □ Radiation seeds or implants
   □ Medication patch (Nicotine, Nitroglycerine)
   □ Any metallic fragment or foreign body
   □ Tissue expander
   □ Surgical Staples
   □ Joint replacement
   □ Bone/joint pin, screw, nail, wire, plate, etc.
   □ IUD
   □ Dentures, or partial plates
   □ Tattoo or permanent makeup
   □ Body piercing jewelry
   □ Hearing aid
   □ Other implant: __________________________
   □ Breathing problem or motion disorder

For your safety: Before entering the MR environment, you must remove all metallic objects such as jewelry, piercings, hearing aids, dentures or partial plates and artificial limbs/prostheses. You will be required to change into clothing provided by the facility prior to scanning. Please consult the MRI Technologist if you have any questions BEFORE you enter the MR System Room. Please be advised that you will be required to wear earplugs during the MRI procedure.

(Continue to other side)
10. Do you have any of the following diseases?

YES  NO

☐  ☐ Diabetes
☐  ☐ Hypertension (High Blood Pressure) If YES, do you take medication? ______
☐  ☐ Kidney Disease If YES, are you on dialysis? ______
☐  ☐ Cancer If YES, what part of the body? ______

When was it diagnosed?

11. As part of your examination, the MRI radiologist may deem it advisable to give you an I.V. injection of gadolinium contrast to more accurately diagnose your condition.

Have you ever had a previous allergic reaction to MRI gadolinium contrast? ☐ YES ☐ NO

If YES, indicate type of reaction: ________________________________

If YES, did you take a 13 hour pre-medication for this exam? ☐ YES ☐ NO

I attest that the answers I have provided to the questions on this form are 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 any information on this form.

Signature (Patient or Guardian): X __________________________ Date: ________ Time: ________

Patient has been MRI safety screened by at least ONE Level II MRI Personnel and all external contraindicated devices have been removed.

By: __________________________ Date: ________ Time: ________

Level 2 Signature __________________________ Date: ________ Time: ________

FOR MRI STAFF ONLY

All inpatients will be cleared for any possible contraindicated/interfering devices including:

☐ YES ☐ NO Foley temperature probe Is it a BARD temperature probe? ☐ YES ☐ NO (if no, must be removed)
☐ YES ☐ NO Rectal temperature probe If YES, was it removed? ☐ YES ☐ NO
☐ YES ☐ NO Metal endo-tracheal tube If YES, was it removed? ☐ YES ☐ NO
☐ YES ☐ NO Endo-tracheal tube with coil/spring If YES, was it removed? ☐ YES ☐ NO
☐ YES ☐ NO Swan-Ganz catheter If YES, was it removed? ☐ YES ☐ NO
☐ YES ☐ NO Ferrous external fixation device If YES, was it removed? ☐ YES ☐ NO
☐ YES ☐ NO Electrodes If YES, are they MR Conditional? ☐ YES ☐ NO (if no, must be removed)
☐ YES ☐ NO Medication patches If YES, was it removed? ☐ YES ☐ NO
☐ YES ☐ NO Pulse oximeter If YES, was it removed? ☐ YES ☐ NO

MRI Staff Signature: __________________________ Date: ________ Time: ________

When verification of MRI compatibility must be made of any questionable interfering device/object by a radiologist, their signature is required:

Device/object in question: __________________________________________

Radiologist Signature: __________________________ Date: ________ Time: ________

IB-730-030 (MR 3/19)  Chart Copy