Outpatient MRI Screening Form

The following items may interfere with MR imaging
and some may be hazardous to your safety

<< Patient sticker >>

Please check YES or No for the following:

YES	NO	
☐	☐	**ANEURYSM CLIPS FROM BRAIN SURGERY**
☐	☐	**CARDIAC PACEMAKER / AUTOMATIC DEFIBRILATOR**
☐	☐	**NEUROSTIMULATOR (for pain control) or DEEP BRAIN STIMULATOR (for Tremors)**
☐	☐	**INDWELLING DEVICE OR CATHETER FOR PAIN MANAGEMENT**
☐	☐	**PROGRAMABLE VP SHUNT (if yes, we will need to verify valve status before & after the MRI)**
		If you experience any clinical changes after the MRI, please notify your referring physician immediately.
☐	☐	**HEARING AID, COCHLEAR IMPLANT, OR STAPES PROSTHESIS**
☐	☐	**SHRAPNEL FROM WARTIME ACTIVITY, BB OR BULLET FRAGMENT FROM A GUNSHOT WOUND**
☐	☐	**HAVE YOU HAD AN INJURY TO THE EYE INVOLVING A METALLIC OBJECT OR FRAGMENT,**
		Even if it was removed. ex: Metallic slivers, shavings, foreign body, Etc.
☐	☐	**VENOUS UMBRELLA OR FILTER TO CORRECT A BLOOD CLOT CONDITION**
☐	☐	**STENTS** (location & date)**:**_____
☐	☐	**INSULIN PUMP**
☐	☐	**TRANSDERMAL PATCH FOR NICOTINE OR OTHER MEDICATIONS**
☐	☐	**REMOVABLE DENTURES OR OTHER <u>REMOVABLE</u> DENTAL APPLIANCES**
☐	☐	**TISSUE EXPANDER FOR BREAST RECONSTRUCTION**
☐	☐	**OTHER METAL IMPLANTS (PLEASE EXPLAIN):**
☐	☐	**TATTOO**
☐	☐	**ARE YOU PREGNANT or NURSING**
☐	☐	**ANY LATEX ALLERGY?**
☐	☐	**ARE YOU ON DIALYSIS**
☐	☐	**DO YOU HAVE A CANCER HISTORY:** _____
☐	☐	**SURGERIES (PLEASE EXPLAIN):** _____

_____

Today's Date: ____/____/____ **Start date of last menstrual period:** ____/____/____

Signature of patient: _____

Signature of parent or guardian: _____

Date of Birth: ____/____/____ **Height:** _____ **Weight:** _____

MRI Staff Only

Patient ID Verification - 2 out of 5 Minimum

Full name stated by Patient or Family Member	DOB stated by Patient or Family Member	Picture ID verifies full name and DOB against new or existing VM records	Armband marked As verified By VM staff Member	DOB and MRN on Armband matched order and/or existing medical record

Screening confirmed with patient - Tech Initials:_____

Creat. _____ **GFR**_____ **Date:**_____ **IV Size/Loc**_____ **Tech**_____