MRI Patient Safety Screening and Consent Form

Procedure Date _____ /_____ /_____ **Patient ID Number** _____

Name _____

Date of Birth _____ /_____ /_____ Male Female Age _____ Height _____ Weight _____ lbs

Reason for MRI and/or Symptoms _____

Please answer the questions below:

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? Yes No
   If yes, please indicate the date and type of surgery:
   Date _____/_____/_____ Type of surgery _____
   Date _____/_____/_____ Type of surgery _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, X-ray, etc.)? Yes No

If yes, please list:	Body part	Date	Facility
MRI	_____	_____	_____
CT/CAT Scan	_____	_____	_____
X-Ray	_____	_____	_____
Other	_____	_____	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? Yes No
   If yes, please describe: _____
4. Have you had an injury to the eye with a metallic object or fragment (e.g., metallic slivers, shavings, foreign body)? Yes No
   If yes, please describe: _____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? Yes No
   If yes, please describe: _____
6. Are you currently taking or have you recently taken any medication or drug? Yes No
   If yes, please list:_____
7. Are you allergic to any medication? Yes No
   If yes, please list:_____
8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for MRI, CT, or X-ray examination? Yes No
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, kidney transplant, Nephrogenic Systemic Fibrosis (NSF), high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? Yes No
   If yes, please describe: _____

For female patients:

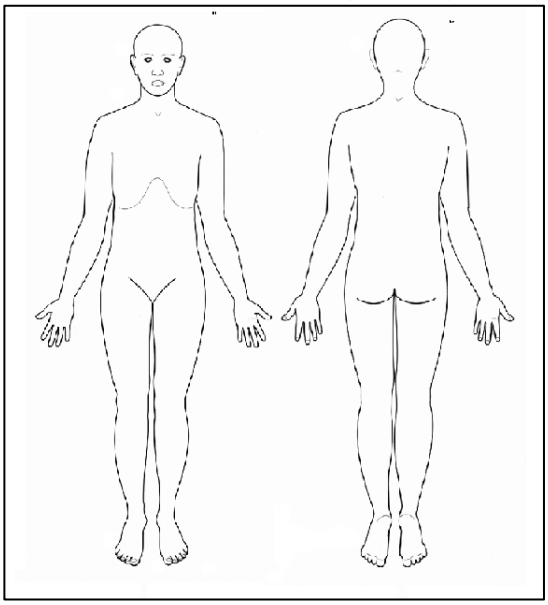
10. Date of last menstrual period:_____/_____/_____
11. Are you pregnant or experiencing a late menstrual period? Yes No
12. Are you taking oral contraceptives or receiving hormonal treatment? Yes No
13. Are you taking any type of fertility medication or having fertility treatments? Yes No
    If yes, please describe: _____
14. Are you currently breastfeeding? Yes No

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

Aneurysm clip(s)	Yes	No
Cardiac pacemaker	Yes	No
Implanted cardioverter defibrillator (ICD)	Yes	No
Electronic implant or device	Yes	No
Magnetically-activated implant or device	Yes	No
Neurostimulation system	Yes	No
Spinal cord stimulator	Yes	No
Internal electrodes or wires	Yes	No
Lap-Band (surgery date _____)	Yes	No
Bone growth/bone fusion stimulator	Yes	No
Cochlear, otologic, or other ear implant	Yes	No
Insulin or other infusion pump	Yes	No
Implanted drug infusion device	Yes	No
Any type of prosthesis (eye, penile, etc.)	Yes	No
Heart valve prosthesis	Yes	No
Eyelid spring or wire	Yes	No
Artificial or prosthetic limb	Yes	No
Metallic stent, filter, or coil	Yes	No
Shunt (spinal or intraventricular)	Yes	No
Vascular access port and/or catheter	Yes	No
Radiation seeds or implants	Yes	No
Thermodilution catheter	Yes	No
Medication patch (Nicotine, Nitroglycerine)	Yes	No
Any metallic fragment or foreign body	Yes	No
Wire mesh implant (IVC filter..)	Yes	No
Tissue expander (e.g., breast)	Yes	No
Surgical staples, clips, or metallic sutures	Yes	No
Joint replacement (hip, knee, etc.)	Yes	No
Bone/joint pin, screw, nail, wire, plate, etc.	Yes	No
IUD, diaphragm, or pessary	Yes	No
Dentures or partial plates	Yes	No
Tattoo or permanent makeup	Yes	No
Body piercing jewelry	Yes	No
Hearing aid	Yes	No
Penile Prosthesis	Yes	No
Breathing problem or motion disorder	Yes	No
Claustrophobia	Yes	No
Jewelry: ring, necklace, earrings...	Yes	No

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MRI area or MRI room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR room.

DOCUMENT all research and verification performed as well as actions taken, if any of the devices and/or implants listed above are present in or on the patient. See MRI Implant-Device Documentation Form.

I have answered these questions to the best of my ability and I understand that possible injury could be a result of my withholding vital information. I consent to undergoing this magnetic resonance imaging examination. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and the MRI procedure.

Patient Signature: _____ **Date:** _____/_____/_____

Other Person completing form: Name:_____ Signature:_____

Form Information Reviewed By: Name:_____ Signature: _____

TIME-OUT Verified correct: []patient []image site []side []positioning By: _____
and reviewed: []MRI screen form for implants and devices Date/Time: _____