



22408-03

2-Hole 1/4 2 3/4 c-to-c



3-Hole 1/4 4 1/4 c-to-c

Children's Healthcare at Webb Bridge
Radiology Center

MRI SAFETY SCREENING FORM

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Account #: _____

PATIENT IDENTIFICATION

Date: _____ Phone Number: _____

Form for: Patient Parent/Guardian Staff Other, explain: _____

Age: _____ Sex: Female Male

Reason for MRI: _____ **Females Only** - Are you pregnant: No Yes

MRI Safety Information:

Because an MRI acts like a giant magnet, loose metallic objects in and around the MRI room can harm anyone in the area, including you and your child. Therefore, before entering the MRI area all metallic and electronic objects must be removed, this includes: hearing aids, keys, beepers, cell phones, hairpins, barrettes, jewelry, body piercing, watch, safety pins, paperclips, money clips, credit cards, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, weapons, and guns.

The MRI system is **ALWAYS** on, so if you have any questions or concerns, please ask the technologist, nurse or radiologist **BEFORE** you enter the MRI room.

The noise that the MRI makes is very loud. In order to prevent possible problems due to the increased noise, earplugs or other hearing protection are required during the scan.

Please carefully read and answer the following questions:

- Have you ever had an MRI? No Yes
If yes, give reason and when _____
Were you sedated for the MRI? No Yes
- Do you have any implanted medical devices? No Yes
If yes, list devices _____
- Have you ever been injured by a metal object (for example: bullet, BB, shrapnel)? No Yes
If yes, please describe _____
- Have you ever had an injury to your eyes involving a metal object or fragment? No Yes
If yes, please describe _____
- Have you ever had any surgery, operation, or heart procedure? No Yes
If yes, please indicate date for the most recent surgeries:
Date ____/____/____ Type of surgery _____
Date ____/____/____ Type of surgery _____
Date ____/____/____ Type of surgery _____
- Have you had any orthodontic work? No Yes
If yes, please describe _____

Name: _____ Date: _____

Please check Yes or No for each box below, or leave blank if you do not understand. If you have any questions, please ask the nurse, technologist, or physician.

<input type="checkbox"/> No <input type="checkbox"/> Yes	Artificial eye, limb, or joint
<input type="checkbox"/> No <input type="checkbox"/> Yes	Aortic clip, aneurysm clips, or vascular clamp
<input type="checkbox"/> No <input type="checkbox"/> Yes	Artificial heart valves, Clam closure device (ASD/VSD)
<input type="checkbox"/> No <input type="checkbox"/> Yes	Body piercing. Locations: _____
<input type="checkbox"/> No <input type="checkbox"/> Yes	Coils, filter or stent - implanted
<input type="checkbox"/> No <input type="checkbox"/> Yes	Orthodontic appliances: dental braces, spacers, palate expanders, or Herbst device
<input type="checkbox"/> No <input type="checkbox"/> Yes	Dentures, removable teeth, or partial plate
<input type="checkbox"/> No <input type="checkbox"/> Yes	Ear or cochlear implant
<input type="checkbox"/> No <input type="checkbox"/> Yes	Electrodes or EKG pads
<input type="checkbox"/> No <input type="checkbox"/> Yes	Electrical or mechanical implant such as penile, internal electrodes or wires
<input type="checkbox"/> No <input type="checkbox"/> Yes	Electronic implant or device - magnetically - activated
<input type="checkbox"/> No <input type="checkbox"/> Yes	Eyelid spring
<input type="checkbox"/> No <input type="checkbox"/> Yes	Feeding tube, if yes, what type _____ <input type="checkbox"/> G-Tube <input type="checkbox"/> Mickey Tube <input type="checkbox"/> Weighted Tube <input type="checkbox"/> Other _____
<input type="checkbox"/> No <input type="checkbox"/> Yes	Hair pins, wig, or barrettes (Remove before entering MRI)
<input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing aid (Remove before entering MRI)
<input type="checkbox"/> No <input type="checkbox"/> Yes	Implanted heart, defibrillator, or pacemaker
<input type="checkbox"/> No <input type="checkbox"/> Yes	Implanted medicine infusion pump such as baclofen, pain medication, insulin, chemo therapy pump
<input type="checkbox"/> No <input type="checkbox"/> Yes	Inserted catheter or port: Tenchoff, broviac, port cath, swan ganz, CVL (central line), etc.
<input type="checkbox"/> No <input type="checkbox"/> Yes	IUD, Diaphragm, or Pessary
<input type="checkbox"/> No <input type="checkbox"/> Yes	Metal rod, plates, screws, nails, pins, or wires
<input type="checkbox"/> No <input type="checkbox"/> Yes	Medicine patch such as nicotine, nitroglycerine, birth control, hormone, pain, or transdermal
<input type="checkbox"/> No <input type="checkbox"/> Yes	Neuro or vagal nerve stimulator including spinal stimulator
<input type="checkbox"/> No <input type="checkbox"/> Yes	Radiation seeds or implants
<input type="checkbox"/> No <input type="checkbox"/> Yes	Spinal fixation device, spinal fusion procedure
<input type="checkbox"/> No <input type="checkbox"/> Yes	Spinal or ventricular shunt
<input type="checkbox"/> No <input type="checkbox"/> Yes	Spinal or ventricular programmable shunt
<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, have you made an appointment at the doctor's office to have it re-programmed? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> No <input type="checkbox"/> Yes	Surgical staples, clips, or metal sutures
<input type="checkbox"/> No <input type="checkbox"/> Yes	Tattoos or tattooed eyeliner
<input type="checkbox"/> No <input type="checkbox"/> Yes	Tissue expanders such as one to enlarge the breast. If yes, what and where: _____

I state that the information on this form is correct to the best of my knowledge. I have read and understand the contents of this form and had a chance to ask questions about the MRI scan, this form and the information on this form.

Signature (Patient may sign only if at least 18 years old) Relationship to patient Date Time

FOR MRI STAFF ONLY		<input type="checkbox"/> Initial Screening: Interview Conducted.
<input type="checkbox"/> Patient Identification		<input type="checkbox"/> MRI Safe Oxygen Tank
<input type="checkbox"/> Patient's Equipment is MRI Safe Equipment		<input type="checkbox"/> Screened with MRI Target Scanner
Patient's Weight (kg) _____		Patient's Height (cm) _____
Signature of Screener (MR Technologist must sign for all clinical exams)	Date	Time