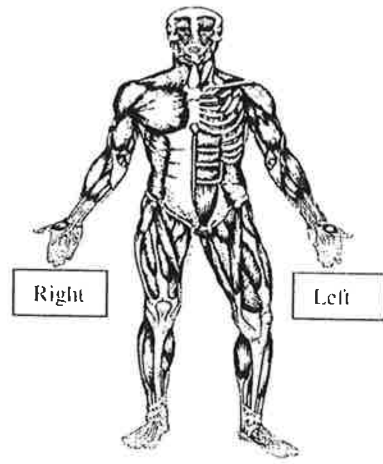
MRI SAFETY SCREENING QUESTIONNAIRE

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 electrocodes or wires	☐ Yes	☐ No
Bone growth/bone fusion stimulator	☐ Yes	☐ No
Cochlear, otology, or other ear implant	☐ Yes	☐ No
Insulin or other infusion pumps	☐ 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
Injury to eye from metal or shards	☐ 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
Swan-Ganz or thermodilution catheter	☐ Yes	☐ No
Medication patch (Nicotine, Nitroglycerine)	☐ Yes	☐ No
Any metallic fragment or foreign body	☐ Yes	☐ No
Wire mesh implant	☐ 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 make-up	☐ Yes	☐ No
Body piercing jewelry	☐ Yes	☐ No
Hearing aid (Remove before entering MR system room)	☐ Yes	☐ No
Other Implants_______________________	☐ Yes	☐ No
Breathing problem or motion disorder	☐ Yes	☐ No
Claustrophobia	☐ Yes	☐ No

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



I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing the form **Form Information Reviewed by:**

______________________________ ______________________________

Date:___/___/___ Print Name

Form Completed by: ☐Patient ☐Relative ☐Nurse ☐Translator ☐MRI ☐Tech ☐Radiologist
Other ______________________________