Patient Name: _____

MR# _____

Date of Birth: _____ Weight: _____

Southwest General

MRI Department Outpatient Checklist

The following items CAN BE HAZARDOUS to the patient's safety. Please check all that apply.

Yes	No		Yes	No	
☐	☐	Cardiac pacemaker ***Patients with Cardiac Pacemakers cannot have MRI examinations!***	☐	☐	Cochlear ear implants
			☐	☐	Breast Tissue Expander
☐	☐	Implanted Defibrillator	☐	☐	Implanted Drug Pump (Insulin/Pain)
☐	☐	Brain Aneurysm clips	☐	☐	Inferior Vena Cava Filter
☐	☐	Any history of eye injury involving metal or metal removed from the eye	☐	☐	Neurostimulator (TENS)

The following items CAN INTERFERE with the MRI examination. Please check all that apply.

Yes	No		Yes	No	
☐	☐	Claustrophobia	☐	☐	Possibility of Pregnancy
☐	☐	Shunt			Date last menstrual period _____
☐	☐	Joint Replacement	☐	☐	History of Renal Disease
☐	☐	History of Brain Surgery	☐	☐	History of Kidney Dialysis
☐	☐	History of Heart Surgery	☐	☐	Metal Rods, Plates, Screws
☐	☐	Cardiac/Vascular Stents	☐	☐	Nails, Shrapnel, Bullets
			☐	☐	Dentures
			☐	☐	Hearing Aids
			☐	☐	Wearing Drug Patch

☐ ☐ History of Cancer? Type _____

☐ ☐ History of Chemo? Date of last treatment _____

☐ ☐ History of Radiation Therapy? Date of last treatment _____

☐ ☐ History of Surgery in the last 6 weeks? If yes, what type? _____

☐ ☐ Permanent Makeup? Tattoos? Location _____

☐ ☐ Have you had an Endoscopy or Colonoscopy in the last 3 months?

I have reviewed the above list and have informed the staff of Southwest General Health Center MRI Department of any possible metal within my body. I understand the risks and hazards associated with inaccurate information. The MRI exam may require an intravenous injection of a contrast agent. The introduction of contrast into the body rarely causes mild to severe reactions. Your signature indicates that you understand the above mentioned information and all of your questions have been accurately answered and that you are giving our facility consent to perform an MRI exam, including the possible injection of a contrast agent as deemed necessary by the radiologist.

Form completed by ☐ Patient ☐ Other

Patient Signature: _____ Relationship to Patient: _____