MRI SAFETY SCREENING FORM FOR PATIENTS

Contrast _____

Creatinine _____

GFR _____

Please read and check YES or NO to the following questions:

☐ Yes	☐ No	Brain aneurysm clip(s)	☐ Yes	☐ No	Shunt (spinal or intraventricular)
☐ Yes	☐ No	Cardiac pacemaker	☐ Yes	☐ No	Vascular access port and/or catheter
☐ Yes	☐ No	Implanted cardioverter defibrillator (ICD)	☐ Yes	☐ No	Radiation seeds or implants
☐ Yes	☐ No	Electronic implant or device	☐ Yes	☐ No	Swan-Ganz or thermodilution catheter
☐ Yes	☐ No	Magnetically-activated implant or device	☐ Yes	☐ No	Medication patch (Nicotine, Nitroglycerine)
☐ Yes	☐ No	Neurostimulation system	☐ Yes	☐ No	Injury to eye involving metallic slivers or foreign body
☐ Yes	☐ No	Spinal cord stimulator	☐ Yes	☐ No	Metallic fragment inside body (shrapnel, bullet, BB. etc.)
☐ Yes	☐ No	Internal electrodes or wires	☐ Yes	☐ No	Wire mesh implant
☐ Yes	☐ No	Bone growth/bone fusion stimulator	☐ Yes	☐ No	Artificial or prosthetic limb
☐ Yes	☐ No	Cochlear, otologic, or other ear implant	☐ Yes	☐ No	Surgical staples, clips, or metallic sutures
☐ Yes	☐ No	Insulin or other infusion pump	☐ Yes	☐ No	Joint replacement (hip, knee, etc.)
☐ Yes	☐ No	Implanted drug infusion device	☐ Yes	☐ No	Bone/joint pin, screw, nail, wire, plate, etc.
☐ Yes	☐ No	Any type of prosthesis (eye, penile, etc.)	☐ Yes	☐ No	IUD, diaphragm, or pessary
☐ Yes	☐ No	Heart valve prosthesis	☐ Yes	☐ No	Dentures or partial plates
☐ Yes	☐ No	Eyelid spring or wire	☐ Yes	☐ No	Tattoo or permanent makeup
☐ Yes	☐ No	Resolution clip in GI Tract	☐ Yes	☐ No	Body piercing jewelry
☐ Yes	☐ No	Endoscopic capsule camera	☐ Yes	☐ No	Hearing aid (remove before entering MR system room)
☐ Yes	☐ No	Pregnant or nursing an infant	☐ Yes	☐ No	Other implant_____
☐ Yes	☐ No	Metallic stent, filter, or coil	☐ Yes	☐ No	Breathing problem or motion disorder
☐ Yes	☐ No	Tissue expander (e.g., breast)	☐ Yes	☐ No	Claustrophobia

NOTE: You will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

VERY IMPORTANT. PLEASE READ and SIGN.

CONTRAINDICATIONS: Since MRI uses a strong electromagnetic field, **you cannot undergo this procedure if you have any of the following:** Cardiac pacemaker; cochlear implant; neurostimulators; metal fragments in the eye; implanted drug infusion pump (Medtronics OK); or certain types of aneurysm clips implanted in the brain. ***Please inform us if you have any other implants not mentioned***

PREGNANCY: Currently there is no known evidence through the FDA and the American College of Radiology of an MRI, with or without contrast, having adverse effects on the fetus. However, it is the policy of this facility to proceed with caution. Please inform a member of our staff if you are pregnant or if you think you might be pregnant.

CONTRAST: Your Doctor may have requested that your exam be performed with intravenous contrast media if necessary during the MRI exam. Our contrast media of choice is OptiMARK®, Magnevist® and Multihance®. OptiMARK®, Magnevist® and Multihance® injections are FDA approved and indicated for use with MRI examinations. Although OptiMARK®, Magnevist® and Multihance® are very safe and allergic reactions are extremely rare, the possibility of an allergic reaction does exist. In addition, related complications such as pain or swelling at the sight of injection or phlebitis, although rare, are possible. The purpose, benefits and complications of the contrast procedure will be explained to your satisfaction before any injection takes place.

******If you are receiving an MRI that requires contrast and you are currently being treated, or have been treated, for renal insufficiency or renal dysfunction due to hepato-renal syndrome or in the perioperative liver transplantation period, please see a member of our staff before beginning your exam.**

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 procedures that I am about to undergo.

_____ _____

PATIENT SIGNATURE/ GUARDIAN'S SIGNATURE (IF PT. IS A MINOR) **DATE**

_____ _____

FORM INFORMATION REVIEWED BY **DATE**