



IV Site:	_____
Gauge:	_____
IV Tech:	_____
Scan Tech:	_____

OUTPATIENT
MRI Department Screening Form **Page 1 of 2**

Today's Date _____ Name _____ Your Weight _____

An MRI involves the use of a very strong magnet. For your safety, the presence of certain metallic objects must be determined before you enter the exam room. Please place a check in the appropriate column for each item below.

	Yes	No		Yes	No
1. Pacemaker/Pacer wires/Implantable defibrillator			16. Are you wearing a patch that delivers medication?		
2. Intracranial or brain aneurysm clip (brain surgery)			17. Do you have a history of difficult IV starts?		
3. Have you had an MRI before? If yes, did you receive a contrast injection?			18. Do you have an implanted port or indwelling catheter?		
4. Have you had an MRI in the past 7 days? If yes, did you receive a contrast injection?			19. Are you on dialysis? If yes, how often: _____		
5. Metallic heart valve or any metallic stents			20. Please <u>list</u> all surgeries: _____ _____ _____		
6. Bio or neurostimulator, electronic device or implant					
7. Tattoo(s), Tattooed eyeliner If yes, location (s): _____					
8. Body piercing If yes, location (s): _____			21. Please <u>circle</u> if you have any of the following medical conditions: Asthma/Hay fever Heart Disease Multiple Myeloma Thyroid Disease Pheochromocytoma Sickle Cell Disease		
9. Metal injury to the eye requiring medical attention					
10. Shrapnel (metal in body)			FEMALES ONLY	Yes	No
11. Eye surgery or prosthesis			22. Is there any possibility of pregnancy?		
12. Ear surgery or prosthesis			23. Intrauterine Device (IUD) or Diaphragm		
13. Limb or joint replacement or pinning			24. Pessary (in pelvis)		
14. Tissue expander (e.g. breast implant)			MALES ONLY	Yes	No
15. Implanted pump (insulin, pain med, chemotherapy)			25. Do you have a penile implant? If yes, make and model: _____		

MRI Staff will speak to you about the need for removing the following items:						
Removable dental work	Eyeglasses	Wallet/keys	Watch/Jewelry	Credit and ATM cards	Hearing aids	Wigs/hairpieces or bobby pins

Patient Signature _____ Relationship (if not the patient) _____ Date ___/___/___

Signature of Nurse or Technologist _____ Date ___/___/___

**PLEASE FILL OUT BOTH
 SIDES OF THIS FORM**

