



MRI Patient Screening

for addressograph plate

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

This section is to be filled out by the PATIENT/ Patient representative. Please complete the following:

Programmable Shunt/shunt <input type="checkbox"/> Yes <input type="checkbox"/> No	Tracheostomy <input type="checkbox"/> Yes <input type="checkbox"/> No
Epidural or Swan Ganz catheter <input type="checkbox"/> Yes <input type="checkbox"/> No	Stimulator/Wires <input type="checkbox"/> Yes <input type="checkbox"/> No
Ear Implant <input type="checkbox"/> Yes <input type="checkbox"/> No	Infusion Pump <input type="checkbox"/> Yes <input type="checkbox"/> No
Cochlear Implant <input type="checkbox"/> Yes <input type="checkbox"/> No	Penile Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Implant <input type="checkbox"/> Yes <input type="checkbox"/> No	IUD <input type="checkbox"/> Yes <input type="checkbox"/> No
Aneurysm Clips <input type="checkbox"/> Yes <input type="checkbox"/> No	Surgical Clips <input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker/wires <input type="checkbox"/> Yes <input type="checkbox"/> No	Bullets, Pellets, BBs <input type="checkbox"/> Yes <input type="checkbox"/> No
Internal Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No	Medication Patch <input type="checkbox"/> Yes <input type="checkbox"/> No
Tissue expander <input type="checkbox"/> Yes <input type="checkbox"/> No	Tattoo <input type="checkbox"/> Yes <input type="checkbox"/> No
Recent Stent Placement <input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Limb <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Vessel Coil <input type="checkbox"/> Yes <input type="checkbox"/> No	Other implanted metal or device _____
*Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No	*On dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No
*Liver or kidney transplant <input type="checkbox"/> Yes <input type="checkbox"/> No	*Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No

*Age : _____ Weight (lbs): _____ Height : _____ Last Menstrual Period? _____

Have you ever been a machinist, welder, or metal worker? Yes No

Have you ever had a facial injury from metal and/or metal removed from your eyes? Yes No

Are you pregnant or Breastfeeding? Yes No

Allergies? (specify): _____

Current Medications: _____

Surgeries? _____

Signature of person completing form: _____ Date: _____

This section is to be filled out by RADIOLOGY STAFF:

Orbit Films? Yes No *Requires GFR? Yes No GFR: _____

Disposition of valuables: Family member MRI Locker # _____ No valuables
Patient/Family has key

Anyone with patient in the MRI room has been cleared for safety requirements? Yes No

MRI Technologist name: _____ Date: _____



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