MIDDLETOWN MEDICAL
Your health care… all in one place!

MRI SAFETY SCREENING QUESTIONAIRE

Name:_____ **Date:_____**

Sex:_____ Age:_____ Height:_____ Weight:_____ DOB:_____

The following items may be harmful to you during your MR scan or may interfere with the MR examination. Please provide a "yes" or "no" answer for every item.

YES	NO	
____	____	Cardiac pacemaker or implanted cardioverter defibrillator/ICD
____	____	Internal electrodes or wires (ex: pacing wires, DBS or VNS wires)
____	____	Artificial heart valve, coil, filter (ex: Gianturco coil, IVC filter)
____	____	STENT(s). If yes, do you have your stent card with you? ____ YES ____ NO
____	____	Aneurysm clip(s)
____	____	Neurostimulator (ex: TENS Unit, Biostimulator, bone growth stimulator, DBS,VNS)
____	____	Implanted drug pump (e.g. insulin, chemotherapy, pain medicine)
____	____	IV access port (ex: Port-a-Cath, Broviac, PICC line, Swan-Gantz, Thermodilution)
____	____	Previous Surgery (if any- check yes, tech will verbally go over surgeries with you)
____	____	Implanted post surgical hardware (ex: pins, rods, screws, plates, wires)
____	____	Artificial joint and/or limb
____	____	Artificial eye and/or eyelid spring
____	____	Eye injury from a metal object (metal shavings/metal slivers)
____	____	Ear (cochlear) implant, middle ear implant
____	____	Hearing aid(s)
____	____	False teeth/dentures, metallic removable dental work, braces, retainers
____	____	Any type of implant held in place by a magnet
____	____	Injured by a metal object (shrapnel, bullet, BB) and required medical attention
____	____	Medication patch (ex: nitroglycerine, nicotine, contraceptive, estrogen)
____	____	Shunt or Sophy adjustable and programmable pressure valve
____	____	Spinal fixation device, spinal fusion, and/or halo vest, spinal cord stimulator
____	____	Surgical clips, staples or surgical mesh
____	____	Tissue Expander (breast)
____	____	Penile implant
____	____	Pessary, IUD, Diaphragm
____	____	Radiation seeds (cancer treatment)
____	____	Body piercing, tattoo or permanent makeup
		Has it been within the last 6 weeks? ___ YES ___ NO
____	____	Wig, hair implants

<u>Do you have a history of:</u>

YES	NO		YES	NO	
____	____	Kidney Disease	____	____	Claustrophobia
____	____	Diabetes	____	____	Drug allergy; type?_____
____	____	High blood pressure	____	____	Latex Allergy
____	____	Liver disease	____	____	Allergic reaction to MRI contrast
____	____	Anemia			(Gadolinium based, Feridex)
			____	____	Seizures

Are you on dialysis? ____ YES ____ NO

If YES, Hemodialysis or Peridialysis? (circle one)

Female Patients:

Are you pregnant? ____ YES ____NO Are you breast-feeding? ____ YES ____NO

If you are still menstruating, please provide the date of your most current period_____

If you answered **YES** to any of the questions on the front page, please discuss any concerns and/or issues you may have, with your MR Technologist.

Instructions of the Patient, Parent, Guardian:
We will provide a locker so **ALL** items you remove may be stored and locked safely during you scan. You may bring the key in the scan room with you.

1. Remove **ALL** jewelry and **ALL** body piercing jewelry and **ALL** hair accessories
2. Remove dentures, false teeth, partial dental places, retainers
3. Remove hearing aids and eyeglasses
4. Please empty **ALL** pockets of **ALL** items you may be carrying
5. Remove **ALL** clothing with metal fasteners, snaps, zippers, and remove your belt
6. Lock your clothes and valuables in the locker provided and remove the key
7. Please use the restroom before your MRI exam
8. Please make sure that you receive a pair of earplugs and/or headphones before your MRI exam begins. Some patients may find the noise levels unacceptable, and the noise levels may affect your hearing.

I attest the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

_____ _____ _____
Patient/Parent/Guardian/Other Signature Date Time

_____ _____ _____
MRI Technologist Date Time

_____

Print Name of MR Technologist

FOR MRI STAFF USE ONLY

CONTRAST ORDER/SIGNATURE	**TO BE FILED IN THE MEDICAL RECORD**

Contrast Type:_____ Injection Rate:_____ Injection Amount:_____

Creatinine Value:_____ BUN:_____ GFR Value:_____ Date Acquired:_____

Creatinine/GFR Screening waived by:_____

MR Technologist Signature: _____ Date:_____ Time:_____