Minidoka Memorial Hospital

MRI PATIENT SAFETY SCREENING FORM

Name _____Age_____ Height _____ Weight _____
Last Name First Name Middle Initial

Date of Birth _____/_____/_____ ▫ Male ▫ Female Body Part to be Examined_____

Please indicate if you have any of the following:

- ▫ Yes ▫ No Aneurysm clip(s)
- ▫ Yes ▫ No Cardiac pacemaker
- ▫ Yes ▫ No Implanted cardioverter defibrillator (ICD)
- ▫ Yes ▫ No Electronic implant or device
- ▫ Yes ▫ No Magnetically-activated implant or device
- ▫ Yes ▫ No Neurostimulation system
- ▫ Yes ▫ No Spinal cord stimulator
- ▫ Yes ▫ No Internal electrodes or wires
- ▫ Yes ▫ No Cochlear, otologic, or other ear implant
- ▫ Yes ▫ No Implanted drug infusion device
- ▫ Yes ▫ No Any type of prosthesis (eye, penile, etc.)
- ▫ Yes ▫ No Heart valve prosthesis
- ▫ Yes ▫ No Eyelid spring or wire
- ▫ Yes ▫ No Artificial or prosthetic limb
- ▫ Yes ▫ No Metallic stent, filter, or coil
- ▫ Yes ▫ No Shunt (spinal or intraventricular)
- ▫ Yes ▫ No Vascular access port and/or catheter
- ▫ Yes ▫ No Radiation seeds or implants
- ▫ Yes ▫ No Medication patch (Nicotine, Nitroglycerine)
- ▫ Yes ▫ No Injury to the eye involving a metallic object or fragment
- ▫ Yes ▫ No Any metallic fragment or foreign body(e.g., BB, bullet, shrapnel, etc.)
- ▫ Yes ▫ No Wire mesh implant
- ▫ Yes ▫ No Joint replacement (hip, knee, etc.)
- ▫ Yes ▫ No Bone/joint pin, screw, nail, wire, plate, etc.
- ▫ Yes ▫ No Dentures or partial plates
- ▫ Yes ▫ No Tattoo or permanent makeup
- ▫ Yes ▫ No Body piercing jewelry
- ▫ Yes ▫ No Hearing Aid (Remove before entering MR system room)
- ▫ Yes ▫ No Other implant _____
- ▫ Yes ▫ No Breathing problem or motion disorder
- ▫ Yes ▫ No Claustrophobia
- ▫ Yes ▫ No Any chance you are pregnant?
- ▫ Yes ▫ No Currently breastfeeding?

Explain (YES) Answers:_____

_____

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 procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date _____/_____/_____

Form Completed By: ▫ Patient ▫ Relative ▫ Nurse _____ _____
Print Name Relationship to Patient

Form Information Reviewed By: ▫ MRI Technologist ▫ Nurse ▫ Radiologist

_____ _____

Minidoka Memorial Hospital

Print Name

Technologist Signature