OUTPATIENT MRI SCREENING

Patient or family member PRIOR to the MRI exam MUST fill out form completely.

Name:_____Date of Birth:_____Weight:_____Height:_____

The following items can interfere with MR imaging and some can actually be hazardous to your safety.

Please check YES or NO if you have any of the following items:

YES NO

QUESTIONS FOR MRI ELIGIBILITY/METAL SCREENING

- ☐ ☐ Have you ever had an MRI scan?
- ☐ ☐ Do you currently have an implanted cardiac pacemaker or defibrillator?
- ☐ ☐ Have you ever had a cardiac pacemaker or defibrillator removed?

DO YOU HAVE:

- ☐ ☐ Aneurysm clips in your brain? If yes, in which institution were they placed?_____
- ☐ ☐ A neurostimulator (TENS Unit), insulin pump or intrathecal pain pump? (Circle all that apply)
- ☐ ☐ Vascular clips, intravascular filters or coils?
- ☐ ☐ Coronary or abdominal stents?
- ☐ ☐ Nitroglycerin, nicotine, or any other medication patches on your body?
- ☐ ☐ A surgically placed shunt? If yes, is it programmable? Yes ☐ No ☐
- ☐ ☐ An artificial heart valves?
- ☐ ☐ Breast tissue expanders?
- ☐ ☐ Any orthopedic hardware *(i.e. pins, rods, screws, nails, wires, or plates)?*
- ☐ ☐ An artificial/prosthetic limb or joint replacement?
- ☐ ☐ A penile Implant, IUD or diaphragm?
- ☐ ☐ Eye implants or tattoo eyeliner?
- ☐ ☐ Body tattoos or piercings?
- ☐ ☐ Dentures? If yes, are they removable? Yes ☐ No ☐
- ☐ ☐ Any metal in your body such as shrapnel, gunshot wound, or BB pellet?
- ☐ ☐ Any pieces of metal in your eyes?
- ☐ ☐ Have you ever in your lifetime been a metal worker, grinder, welder, machinist, etc. as a hobby or profession?
- ☐ ☐ Have you ever had surgery to your inner ear? Ear implants? Yes ☐ No ☐ | Hearing aids? Yes ☐ No ☐

QUESTIONS FOR GADOLINIUM CONTRAST ADMINISTRATION

- ☐ ☐ **Do you have any allergies?** If yes, please list: _____

_____

- ☐ ☐ Are you allergic to MRI contrast? If yes, have you been pre-medicated? Yes ☐ No ☐
- ☐ ☐ Do you have kidney problems, decreased kidney function, or a family history of kidney problems?
- ☐ ☐ Have you ever had kidney surgery or been on dialysis?
- ☐ ☐ Do you have diabetes (Insulin or Non-insulin dependent)?
- ☐ ☐ Are you pregnant or do you suspect that you could be pregnant? Are you nursing an infant? Yes ☐ No ☐
- ☐ ☐ If you have a venous access port, do you need it accessed?
- ☐ ☐ Have you had any surgery within the past 6 weeks?
- ☐ ☐ Have you ever had surgery? If so, what type?_____

In the past week, have you experienced any of the following: nausea/vomiting, diarrhea, fever/chills? If so, please specific? _____

_____

PATIENT/WITNESS SIGNATURE		DATE	LEVEL 1/2
RELATIONSHIP	PRINT NAME		LEVEL 2

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Neighborhood Clinics – Valley Medical Center
University of Washington Physicians Seattle, Washington

OUTPATIENT MRI SCREEN

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