

OUTPATIENT MRI SCREENING

Patient or family member PRIOR to the MRI exam MUST fill out the 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
- 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 inner ear surgery? 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 specify: _____

PATIENT (OR LEGAL GUARDIAN) SIGNATURE		DATE	LEVEL 1/2
PATIENT NAME (PRINTED)	LEGAL GUARDIAN PRINTED NAME (IF APPLICABLE)	LEVEL 2	

PLACE PATIENT LABEL HERE

UW Medicine
 Harborview Medical Center – University of Washington Medical Center
 UW Medicine Primary Care – Valley Medical Center – UW Physicians

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