OUTPATIENT MRI SCREENING

Name:_____ Date of Birth:_____ Height:_____ Weight:_____

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

Please indicate 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 restless legs, tremors or are you unable to lie flat?

Please indicate if you have:

- ☐ ☐ Aneurysm clips in your brain? If yes, in which institution were they placed: _____
- ☐ ☐ A neurostimulator, deep brain stimulator, vagus nerve stimulator, spinal cord stimulator (implanted or removed)?
- ☐ ☐ An implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)?
- ☐ ☐ Any internal electrodes (e.g., doppler wires, abandoned or fractured leads)?
- ☐ ☐ Vascular clips, GI clips, intravascular filters, artificial heart valves, or coils?
- ☐ ☐ A capsule endoscopy or ingested a “pill cam” in the last six months?
- ☐ ☐ Coronary, abdominal, vascular, or other stents in your body?
- ☐ ☐ An implant held in place or controlled by a magnet (e.g., programmable shunt)?
- ☐ ☐ A surgically placed non-programmable shunt (e.g. TIPS)? If yes, what type: _____
- ☐ ☐ A loop recorder?
- ☐ ☐ Eye implants?
- ☐ ☐ Breast tissue expanders?
- ☐ ☐ Any orthopedic hardware (e.g., pins, rods, screws, nails, wires, or plates)?
- ☐ ☐ An artificial/prosthetic limb or joint replacement?
- ☐ ☐ A penile implant, IUD, Implanon/Nexplanon, or diaphragm birth control?
- ☐ ☐ A glucometer sensor or any medication patches (e.g., nitroglycerin, nicotine, hormone, anti-nausea, pain)?
- ☐ ☐ Any metallic make-up/nail polish, piercings, or hair implants/accessories (e.g., bobby pins, clips, extensions)?
- ☐ ☐ Tattoos or tattooed eyeliner placed within the last 6 weeks?
- ☐ ☐ 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?
- ☐ ☐ Worked as metal worker, grinder, welder, machinist, etc. as a hobby or profession?
- ☐ ☐ Surgery to your inner ear?
- ☐ ☐ Ear implants (e.g., cochlear, Baha, stapes prosthesis, or tubes)?
- ☐ ☐ Hearing aids?
- ☐ ☐ Any other type of surgically implanted medical devices, removable medical devices or personal items not covered above? If yes, what type: _____

QUESTIONS FOR GADOLINIUM CONTRAST ADMINISTRATION

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

_____

- ☐ ☐ Are you allergic to MRI contrast? If yes, are you 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 ☐
- ☐ ☐ Have you received an iron or Feraheme injection in the past 3 months?
- ☐ ☐ If you have a venous access port, do you need it accessed?
- ☐ ☐ Have you had 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: _____

PLACE PATIENT LABEL HERE