



MRI PROCEDURE SCREENING FORM

NAME: _____

AGE: _____

DATE OF BIRTH: _____

ALLERGIES: _____

WEIGHT: _____

HEIGHT: _____

For Office Use Only

MRN: _____

ORDERING
PROVIDER: _____

APPT DATE: _____

BODY PART: _____

TIME: _____

The MRI system has a very strong magnetic field that may be harmful to individuals that have certain implants, devices, or metallic/mechanical devices. Therefore ALL individuals are required to fill out this form BEFORE entering the MRI environment. Be advised, the magnet is ALWAYS on.

IF YES TO ANY, STOP AND CONTACT MRI

YES NO

- ☐ ☐ Surgery, endoscopy, colonoscopy with marker
placement in past 8 weeks. _____
- ☐ ☐ Cardiac Pacemaker or Defibrillator.
- ☐ ☐ Aneurysm Clips. Where? _____
- ☐ ☐ Cochlear Implants.
- ☐ ☐ Deep Brain Spine or ANY Neurostimulators.
- ☐ ☐ Do you currently or have a history of seizures?
- ☐ ☐ Implanted Pain Medicine Pump
- ☐ ☐ Glucose Monitor

**PLEASE
READ**



DIABETIC PATIENTS

You will be asked to remove your Dexcom monitor prior to your MRI.

ALL PATIENTS

Before entering the MR environment or system room, you will remove hair pins, jewelry, body piercings, watches, safety pins, money clips, credit cards, belts, bank cards, nail clippers, tools, cell phones pagers, fitbits, clothing with metal fasteners and clothing with metal.

MRI PROCEDURES SCREENING FORM

YES NO

- ☐ ☐ Claustrophobic
- ☐ ☐ Artificial Heart Valve _____
- ☐ ☐ Prior Surgeries To Body Part to be Scanned
- ☐ ☐ Heart Surgery
Type: _____
- ☐ ☐ Electrodes (Internal or External)
- ☐ ☐ Loop Recorder/ICM Implant
- ☐ ☐ Shunts/Stents/Filters/Grafts
Where: _____
- ☐ ☐ Metal Mesh
Where: _____
- ☐ ☐ Any Type Of Tissue Expander
Where: _____
- ☐ ☐ Head (Brain) Surgery
Explain: _____
- ☐ ☐ Inner Ear Surgery Besides Tubes
- ☐ ☐ Hearing Aid (Remove Before Entering Room)
- ☐ ☐ Eye Surgery
Explain: _____
- ☐ ☐ Metal Injuries Removed From Eyes (Ever)
- ☐ ☐ Dialysis from Kidney Failure

YES NO

- ☐ ☐ Insulin Pump/Glucose Monitor
(Has to be Removed)
- ☐ ☐ Personal History Of Cancer
Type: _____
- ☐ ☐ Physical Disabilities
Explain: _____
- ☐ ☐ Prosthesis - Any Kind (i.e. Eye, Penile, Leg)
Where: _____
- ☐ ☐ Shrapnel
Where: _____
- ☐ ☐ Joint Replacement
Where: _____
- ☐ ☐ Metal Rods, Pins or Plates
Where: _____
- ☐ ☐ Do you have any other objects medically
implanted in or on your body?
Where: _____
- ☐ ☐ Any Transdermal Patches
- ☐ ☐ Pregnant/Nursing
- ☐ ☐ Tattoos/Permanent Makeup
- ☐ ☐ Body Piercing
Where: _____

NOTE: You will be required to wear earplugs or headphones which we provide during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date: _____

Form Completed By: ☐ Patient ☐ Relative ☐ Other _____

Print Name: _____ Relationship to Patient: _____

Form Reviewed By: _____ Date: _____