Safety Screening Form for Magnetic Resonance (MR) Procedures

Tel: 636 333 1391 Fax: 636 333 1343
E-mail: info@specialTMRI.com
1823 Smizer Station Rd, Fenton, MO 63025

Date: _____

Name (first, middle, last): _____

Gender: ☐ Male ☐ Female Age: _____ Date of Birth: ____/_____/_____

Height: _____ Weight: _____

If uncertain of any answer below, please circle and leave blank to discuss with the technologist.

Why are you having this examination (medical problem)?

_____

List current medications:

☐ None

☐ _____

_____

List all allergies:

☐ None

☐ _____

_____

Date of last menstrual period _____

☐ Yes ☐ No Is there a possibility that you are pregnant?

☐ Yes ☐ No Are you post-menopausal?

☐ Yes ☐ No Are you breast feeding?

Please indicate if you have or have not had any of the following:

☐ Yes ☐ No Previous MRI examination

Facility name and city: _____
Date of examination: _____
Body part imaging: _____ Reason for examination: _____

☐ Yes ☐ No Surgery or medical procedure of any kind
If yes, list all prior surgeries and approximate dates: _____

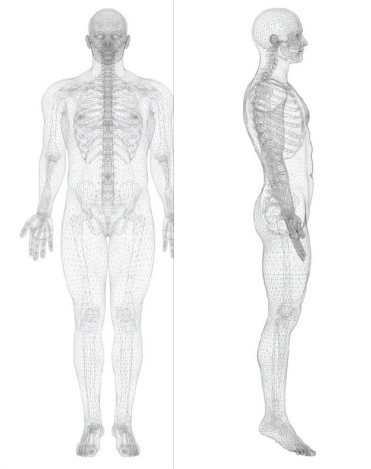
_____

_____

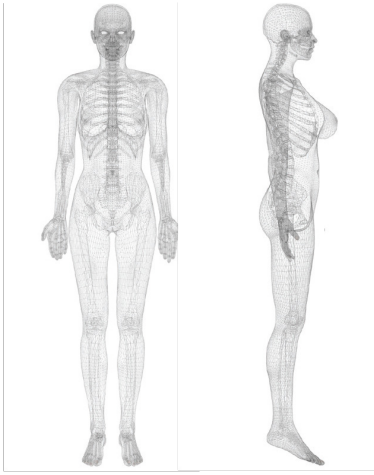
MR Hazard Checklist

Please mark the location of any implant, device or metallic foreign body inside your body or site of surgical operation.

Male:



Female:



☐ Yes ☐ No Injury by a metal object or foreign body (e.g., bullet, BB, shrapnel) If yes, explain:

_____

☐ Yes ☐ No Injury to your eye from a metal object

☐ Yes ☐ No If yes, did you see medical assistance? If yes, describe what was found:

_____

☐ Yes ☐ No Foreign body removed from eye If yes, describe what was taken out:

_____

☐ Yes ☐ No Asthma or other allergic respiratory disease

☐ Yes ☐ No Kidney disease

☐ Yes ☐ No Diabetes

☐ Yes ☐ No Hypertension

☐ Yes ☐ No Previously received contrast agent (dye) for a CT, MRI or other X-ray or study

☐ Yes ☐ No Allergic reaction to CT, MRI, X-ray contrast agent (dye) If yes, explain:

_____

☐ Yes ☐ No Spinal fusion procedure

☐ Yes ☐ No Endoscopy or colonoscopy in last three months

The following items may be harmful to you during your MR scan and may interfere with the MR examination. You must provide a "Yes" or "No" answer for every item.

Please indicate if you CURRENTLY HAVE or HAVE EVER HAD any of the following:

Surgically implanted medical devices

☐ Yes ☐ No Any type of electronic, mechanical or magnetic implant
If yes, list type: _____

☐ Yes ☐ No Cardiac pacemaker, defibrillator or other cardiac implant (in place or removed)

☐ Yes ☐ No Aneurysm Clip

☐ Yes ☐ No Neurostimulator, diaphragmatic stimulator, deep brain stimulator, vagus nerve stimulator, bone growth stimulator, spinal cord stimulator, or any biostimulator (in-place or removed)
If yes, list type: _____

☐ Yes ☐ No Any type of internal electrodes or wires

☐ Yes ☐ No Cochlear implant

☐ Yes ☐ No Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)

☐ Yes ☐ No Spinal fixation device

☐ Yes ☐ No Any type of coil, filter or stent
If yes, list type: _____

☐ Yes ☐ No Artificial heart valve

☐ Yes ☐ No Any type of ear implant

☐ Yes ☐ No Penile implant

☐ Yes ☐ No Artificial eye

☐ Yes ☐ No Eyelid spring and/or eyelid weight

☐ Yes ☐ No Any type of implant held in place by a magnet

☐ Yes ☐ No Any type of surgical clip or staple

☐ Yes ☐ No Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, PICC line)

☐ Yes ☐ No Shunt

If yes, type: _____

☐ Yes ☐ No Artificial limb

If yes, what and where: _____

☐ Yes ☐ No Tissue Expander (e.g., breast)

☐ Yes ☐ No IUD

If yes, type: _____

☐ Yes ☐ No Surgical mesh

If yes, location: _____

☐ Yes ☐ No Radiation seeds

☐ Yes ☐ No Any implanted items (e.g., pins, rods, screws, nails, plates, wires)

Removable medical devices

☐ Yes ☐ No Hearing aid

☐ Yes ☐ No Removable drug pump (e.g., insulin, Baclofen, Neulasta)

☐ Yes ☐ No Any type of ear implant

☐ Yes ☐ No Artificial eye

☐ Yes ☐ No Any type of implant held in place by a magnet

☐ Yes ☐ No Any type of surgical clip or staple

☐ Yes ☐ No Medication patch (e.g., nitroglycerine, nicotine)

☐ Yes ☐ No Artificial limb

If yes, what and where: _____

☐Yes ☐ No Removable dentures, false teeth or partial plate

☐Yes ☐ No Diaphragm, pessary

If yes, type: _____

☐Yes ☐ No Have you recently ingested a "pill cam?"

If yes, date "pill cam" was ingested: _____

Personal

☐Yes ☐ No Body piercings

If yes, location: _____

☐ Yes ☐ No Wig, hair implants

☐ Yes ☐ No Tattoos or tattooed liner

☐ Yes ☐ No Any hair accessories (e.g., bobby pins, barrettes, clips, extensions, weaves)

☐ Yes ☐ No Jewelry

☐ Yes ☐ No Metal-containing clothing material and/or underwear

☐ Yes ☐ No Magnetic cosmetics and hair care (e.g., magnetic eyelashes, magnetic nail polish)

☐ Yes ☐ No Electronic monitoring or tagging equipment (e.g., ankle monitor)

☐ Yes ☐ No Fitness tracker/biomonitor (e.g., Fitbit)

☐ Yes ☐ No Any other type of surgically implanted medical devices, removable medical devices or personal items not covered above?

If yes, type: _____

Is there anything else you would like the MRI technologist or radiologist know?

_____

_____

_____

_____

_____

_____

_____

_____

Instructions for Patients

1. You will be provided hearing protection during your scan. You are strongly urged to use the earplugs or headphones provided to you during your MR examination, since some patients find the noise levels unacceptable, and the noise levels may affect your hearing if these provided hearing protection devices are not utilized.
2. Remove all jewelry and piercings (e.g., necklaces, pins, rings)
3. Remove all body piercings
4. Remove all hair pins, bobby pins, barrettes, clips, etc.
5. Remove all dentures, false teeth, partial dental plates
6. Remove eyeglasses and hearing aids
7. Remove watches, cell phones and pagers
8. Remove all cards with magnetic strips (e.g., credit cards, bank cards, etc.)
9. Because some clothing may contain metal even when not apparent, the MR technologist will instruct you to remove all clothing and worn/removable items from your body. MR Safe clothing will be provided to you to wear during your MRI scan. This is being done to help ensure your safety during the examination.
10. If you are unable to remove any of the above items please notify the technologist.

I state that the information on this form is correct to the best of my knowledge. I read and understand the contents of this form.

Patient signature: _____ Date: _____/_____/_____

MD/RN/RT signature: _____ MD/RN/RT printed name: _____

Safety Screening for Magnetic Resonance (MR) Procedures

FOR MR Office Use Only

Patient name: _____ Patient ID # _____

Referring Physician: _____

Procedure: _____ Diagnosis: _____

Clinical History: _____

Hazard Checklist for Level 2 MR Personnel

☐ Yes ☐ No Pulse oximetry device

☐ Yes ☐ No EKG pads/leads

☐ Yes ☐ No Endotracheal tube

☐ Yes ☐ No Swan-Ganz catheter

☐ Yes ☐ No Extra ventricular device

☐ Yes ☐ No Arterial line transducer

☐ Yes ☐ No Foley catheter with temperature sensor and/or metal clamp

☐ Yes ☐ No Rectal probe

☐ Yes ☐ No Esophageal Probe

☐ Yes ☐ No Tracheotomy tube

☐ Yes ☐ No Guidewires

☐ Yes ☐ No Halo vest

☐ Yes ☐ No Other

If yes, explain: _____

_____

If any Level 2 MR Personnel checklist items are answered yes, this should be brought to the attention to the covering MR Physician.

☐ Yes ☐ No Patient screened with ferromagnetic detector

☐ Yes ☐ No eGFR indicated for contrast

eGFR value: _____ Results date:_____

☐ Yes ☐ No If required, the patient was provided the Medication Guide

Cleared by:

MR Technologist: _____

Physician/Radiologist (if required) _____

05.20