Patient History and Medical Conditions					
Complete the following questions:	**YES**	**NO**	**Complete the following questions:**	**YES**	**NO**
Diabetic			History of head trauma		
Smoker			History of seizure(s)		
Hypertensive			Have you ever had cancer? Type?		
Renal Failure or Dialysis					
Asthma/Respiratory Disease			Did you receive chemo?		
Premature birth? Gestational age?			Did you receive radiation?		
History of claustrophobia or anxiety			History of injury/ accident involving any metalic object or bullet, BB, shrapnel, metal slivers/shavings		
Ever gotten metal shavings in your eyes?					
Swan-Ganz catheter, thermodilution catheter or similar cardiovascular device?					
			Halo vest		
Are you presently breast feeding?			**Personal belongings and Miscellaneous Items**		
Other disease or condition:			**IMPORTANT INSTRUCTIONS**		
MRI History					
Have you ever had:	**Yes**	**No**	**Before entering the MRI room, you must remove ALL metallic objects including hearing aids, dentures, parital plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercings, watch, safety pins, paper clips, money clip, credit cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metallic fasteners or metallic threads and steel toe shoes.**		
MRI exam before? If yes, any problems or concerns?					
Injection of x-ray dye or MRI contrast?					
An allergic reaction to x-ray or MRI contrast?					
History of kidney disease?					

Please consult the MRI Technologist or Radiologist if you have any question/concern BEFORE you enter the MRI room.
NOTE: You may be advised or required to wear hearing protection to prevent possible problems related to noise.

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

Patient/Designee Signature: _____ Date_____ Time_____

Form Completed By: _____Patient ____Relative ____Other Relationship to Patient _____

Hazard Checklist for MRI Personnel (Completed by MR Associate)					
	YES	NO		YES	NO
EKG Leads/Guide Wires			Medical Patches		
Arterial Line Transducer			Foley with Metal Clamps		
Swan-Ganz Catheter			Trach Tube		
Extra-Ventricular Device			ET Tube		
Rectal and/or Esophageal Probe			**Patients gown checked for snaps**		
Additional Comments:					

Contrast Administration (Completed by MR Associate)	
Creatinine Level- GFR-	Type of Contrast- Flush-
Gauge_____ Attempts___ Injection Site_____	Total ML_____ ML Admin_____ Wasted_____
By:_____	Lot# _____ Exp._____

Information Reviewed By:

MR1 Signature:_____ Date _____ Time _____

MR2 Signature:_____ Date_____ Time _____

Notes: _____

(Place Patient Identification Sticker Here)

Methodist Le Bonheur Healthcare

MRI Safety Screening Form

Sex:_____ Age:_____ Weight:_____ Height:_____

Referring MD:_____

Reason for exam:

NOTE: Your physician has requested a MRI examination. MRI utilizes a **strong magnet** and radio frequencies. No long-term effects have been identified, however, **serious injury may occur** when entering the MRI scan room **if your information is inaccurate and incomplete**.

Please check **YES** or **NO** to indicate if you have the following:

Answer "YES" or "NO"	YES	NO	Answer "YES" or "NO"	YES	NO
Brain aneurysm clip			Artifical limb or joint		
Pregnancy or suspect pregnancy			Tissue expander (e.g. breast)		
Pacemaker (Have you ever had?)			Radiation seeds (e.g. cancer treatment)		
Implanted cardiac defibrillator (ICD)			Vascular access port (e.g. Broviac, Port-a-cath, Hickman line, PICC line		
Artifical heart valve					
Neurostimulator/ Biostimulator (e.g. Brain, Bone Growth VNS or Spinal cord)			Prosthesis (e.g. eye, penile, etc.)		
			Medication patch (e.g. pain, nitroglycerine)		
Shunt - If YES, is it programmable?			Tattoos, Tattooed make-up		
Implanted drug pump (e.g. Insulin, Baciofen, Chemotherapy or Pain)			Palette expander		
			Braces, caps, spacers or retainer		
Stents, Coils or Filters			Dentures, false teeth, partial plates, dental post or implant		
Cochlear implant or other ear implant					
IUD, Diaphragm, Pessary or Other item implanted for birth control			Eyelid spring or wire		
			Body piercings		
Any type of electronic or mechanical implant or magnetically held/activated device			Hearing aid		
			ANY other implant		
Any type of internal electrodes or wires			Breathing problem or motion disorder		
Surgical clips, staples, pins, rods, screws,			Trach (If so, what type?)		
Spinal fusion procedure or fixation device			Any metallic fragment or foreign object		
Surgical mesh implant			Hair accessories, bobby pins, wig, etc		

Surgery history/date:
Implant type/location/date:

MR 1 Signature_____ Date_____ Time_____