MRI SAFETY SCREENING QUESTIONNAIRE

Newport Diagnostic Center

Name:	Date of Birth:	MRN:
Today's Date:	Height:	Weight:

Magnetic resonance imaging (MRI) systems use strong magnetic fields and radio-frequency energy for imaging soft tissue in the body. Certain implants, devices, or objects may pose a hazard to individuals in close proximity to the magnet of the MRI system and/or may interfere with the MRI procedure.

What body part is being examined today? _____

What medical imaging tests and/or treatments have you had for this problem? (Prior MRI, injections, etc.)

_____ When_____ Where _____

Have you had surgery in the body part that is being scanned today? ☐ Yes ☐ No

If yes, when (approximate date)? _____ Procedure: _____

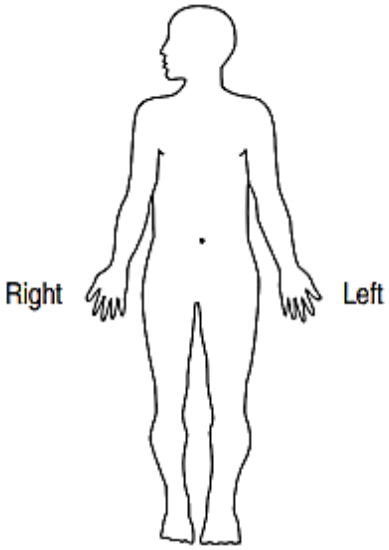
Please describe your symptoms: _____

_____

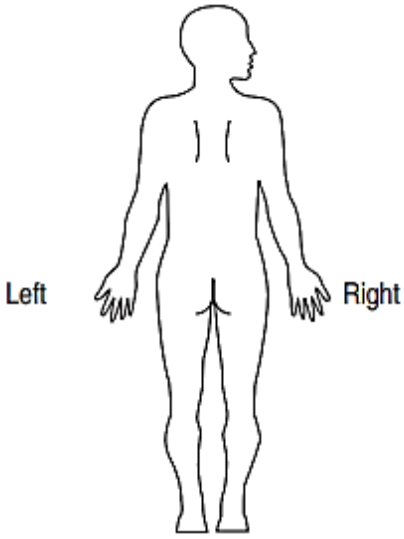
Do you have a personal history of Cancer? ☐ Yes ☐ No

If yes, please indicate the type of cancer: _____

Please shade in the areas below in the figures where you are experiencing your pain/symptoms.



Front



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MRI SAFETY SCREENING QUESTIONNAIRE, continued ****** Please provide any Implant Card you have****

Do you have you any of the following implants?

YES	NO	
☐	☐	Cardiac pacemaker or implanted cardioverter defibrillator/ICD (in place or removed)
☐	☐	Heart Valve
☐	☐	Aneurysm Clips or Coils If yes, Where in your body? _____
☐	☐	Cardiac monitor / Loop recorder
☐	☐	Internal electrodes or wires *(pacing wires, DBS or VNS wires)*
☐	☐	Stents If yes, Where in your body? _____
☐	☐	Shunt (do you know the name and make of your shunt? _____
☐	☐	Neurostimulator
☐	☐	Bone Growth Stimulator
☐	☐	Filters If yes, Where in your body? _____
☐	☐	Ear (Cochlear) implant, middle ear implant
☐	☐	Tissue expander
☐	☐	Magnetic eyelashes
☐	☐	Implanted drug pump *(ex; for chemotherapy/other pain medicine)*
☐	☐	External drug pump / or monitor *(for Insulin or other medicine)*
☐	☐	IUD If yes, what Brand / type: _____
☐	☐	Hearing aids (Must be removed prior to entering the MRI suite)
☐	☐	Body Piercing (you may be asked to remove all jewelry)
☐	☐	Have you EVER had metal in your eyes? If yes, was it removed? _____

Implanted post-surgical hardware (pins, rods, screws, plates, wires)? ☐ Yes ☐ No

If yes, what and where in your body? _____

Any other implanted devices in your body not listed above? ☐ Yes ☐ No

_____

Are you pregnant or could you possibly be pregnant? ☐ Yes ☐ No Are you breast-feeding? ☐ Yes ☐ No

If you are still menstruating, please provide the date of your last period _____

Do you have a history of?

YES	NO		YES	NO	
☐	☐	Kidney disease	☐	☐	Are you on Dialysis
☐	☐	Diabetes	☐	☐	Allergic reaction to MRI contrast
☐	☐	Drug Allergy, type: _____			

I attest 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/Parent/Guardian/other Signature Date