## *Newport Diagnostic Center*

**MRI SAFETY SCREENING QUESTIONNAIRE**

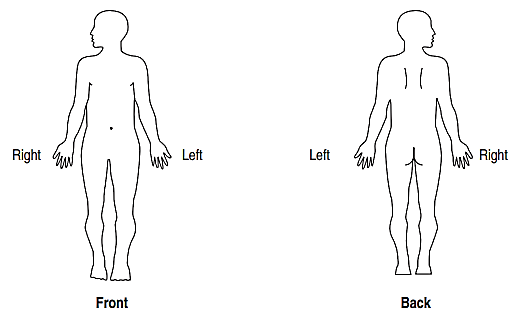
|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Date of Birth: | | MRN: |
| Today’s Date: | Height: | Weight: | |



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 Back**

**Please continue on page 2**

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

Do you have 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 / ICM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ |
|  |  | 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 and/or Spinal cord stimulator / IPG? |
|  |  | 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 Medication Patches?  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