

Patient Name (Last, First, Middle) \_\_\_\_\_ MRN \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Radiologist Name (Last, First, Initial) \_\_\_\_\_

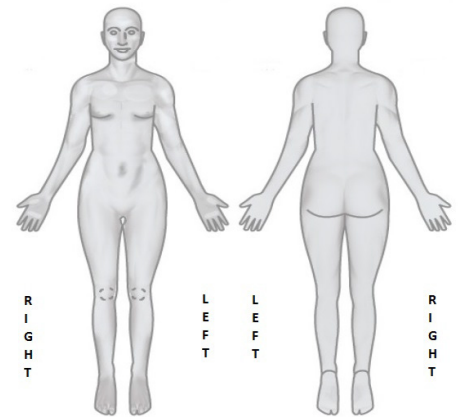
**STOP** **STOP: If you have anything on or in your body you weren't born with, notify your Technologist.** Failure to remove or notify your technologist may result in damage (to you or your device) due to the strong magnetic field. Also, certain invisible metallic microfibers in garments have been reported to heat during an MRI scan. Changing out of street clothes minimizes this risk.

- YES  NO 1. **Have you had anything implanted or attached to your body that you weren't born with?**
- YES  NO 2. Have you had heart surgery or a heart procedure?
- YES  NO 3. Have you worked with metals or had an injury to the eye involving a metallic object or fragment (metallic slivers, shavings, foreign body, etc.)? If yes, describe: \_\_\_\_\_
- YES  NO 4. Have you had metallic slivers, shavings, shrapnel, bullet fragments or a foreign body anywhere in your body?
- YES  NO 5. Have you had a procedure within the past month where you swallowed a special stomach capsule camera or ph monitor?
- YES  NO 6. Have you taken a medication for iron deficiency, such as Feraheme, in the last 3 months?
- YES  NO 7. Are you taking oral contraceptives or receiving hormonal treatment?
- YES  NO 8. Are you taking any type of fertility medication or having fertility treatments? If yes, describe: \_\_\_\_\_
- YES  NO 9. Are you pregnant or nursing?

**Do You Have:**

- YES  NO 10. Medication administration pump, patch or on body injectors (insulin, chemotherapy, pain, nicotine, nitroglycerine, hormonal, etc.)
- YES  NO 11. On body monitor or anything affixed to your skin (blood glucose, etc.)
- YES  NO 12. Any type of magnetic implant or prosthesis (eyelashes, septal closures, CPAP implant, dental posts and crowns, etc.)
- YES  NO 13. Pacemaker or internal defibrillator and leads or abandoned leads
- YES  NO 14. Heart valve prosthesis
- YES  NO 15. Aneurysm clips(s), surgical clips, metal clips or metal sutures in the body
- YES  NO 16. Nerve or tissue stimulators (vagus nerve, deep brain stimulator, TENS unit, etc.)
- YES  NO 17. Shunt (spinal or intraventricular)
- YES  NO 18. Metallic stent, filter, or coil (Gianturco, Gunther IVC Filter, etc.)
- YES  NO 19. Wire mesh implant
- YES  NO 20. Internal electrodes or wires
- YES  NO 21. Bone growth/bone fusion stimulator
- YES  NO 22. Cochlear, otologic or other ear implant
- YES  NO 23. Hearing aid
- YES  NO 24. Lens implant, eyelid spring/wire
- YES  NO 25. Any type of prosthesis (limb, eye, penile, etc.)
- YES  NO 26. Joint replacement (hip, knee, etc.)
- YES  NO 27. Bone/joint pin, screw, nail, wire, plate, etc.
- YES  NO 28. Artificial prosthetic limb
- YES  NO 29. An inflatable breast implant, tissue expander implant, or breast biopsy marker
- YES  NO 30. An IUD, diaphragm, or pessary
- YES  NO 31. Vascular access port and/or catheter, Swan-Ganz or thermodilution catheter
- YES  NO 32. Radiation seeds or implants
- YES  NO 33. Body piercing jewelry, hardware or dermal piercing
- YES  NO 34. Tattoo or permanent makeup
- YES  NO 35. Dentures or partial plates, bridge or dental implants including magnetic posts or plates.

**Mark on the figure(s) below the location of any surgery site or scar on your body**



**NOTE: You will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible hazards related to acoustic noise.**

**IMPORTANT INSTRUCTIONS:** Before entering the MRI environment and room, please remove all objects from your pockets. Also remove hearing aids, dentures/partial plates, on-body injectors/patches, eyeglasses, hair accessories, all jewelry, and clothing with metal fasteners and antimicrobial clothing with metallic threads (e.g. Under Armour, Lululemon, Tommie Copper, etc.). Failure to remove these or notify your technologist of them may result in damage to you and/or your item(s).

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

Signature of Person Completing Form: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Print Name: \_\_\_\_\_ If Not Patient, Relationship to Patient: \_\_\_\_\_

Form Information Reviewed: \_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_

MRI Technologist  Nurse  Radiologist  Other \_\_\_\_\_ Date/Time \_\_\_\_\_