



MRI Screening Questionnaire for Non Patients

Visitor's Name: _____

Date: _____

Patient Name: _____

Relationship: _____

This questionnaire is designed to assist us in determining if it is safe for you to enter into the MRI exam room (whether during a MRI procedure or not). It is important that you answer all of the following questions. **If you don't understand any question, please ask for assistance.**

- | | | | |
|---|------------------------------|-----------------------------|-------------------------------------|
| 1. Do you have a pacemaker, wires, defibrillator, or implanted heart valves? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 2. Have you ever had any head surgery requiring aneurysm clips? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 3. Have you ever had any type of surgery? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 4. Do you have any surgically implanted metal of any type in your body? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 5. Have you ever been exposed to metal fragments that could be lodged in your eyes or body? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 6. Do you have a hearing aid, middle/inner ear prosthesis or dentures? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 7. Do you have any metal pin, joint, prosthesis or metallic object in, or attached to, your body? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 8. Do you have or have you ever had any body piercing? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 9. Do you have any type of electronic device (stimulator or pump) implanted in your body? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 10. If you are a woman – are you pregnant, or is it possible that you might be pregnant? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| 11. Is there any other item or device you believe we should know about prior to entering the MRI exam room – if yes, please describe: | | | |

I certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform the Center of any metal fragments and/or devices that may be in my body and that by failing to do so may cause serious bodily injury or be life threatening. I agree that should I have any metal in my body and, after consultation with a physician, elect to enter into the MRI exam room whether during a MRI procedure or not, I agree to release Center from any and all liability for any injury.

Visitor Signature

Print Name

Date

Witness or Interpreter Signature

Print Name

Date

Physician/Registered Nurse/Technologist

Print Name and Title

Date

Technologist Notes: _____

