Imaging Partners of St. Peters

MRI Patient Safety Screening Form

Date_____ Procedure_____ Patient #_____

Name_____ Date of Birth_____

Address_____Height/Weight_____

Contact Phone Number: _____ Physician _____

PLEASE READ **THE MRI CONTAINS A VERY STRONG MAGNET THAT CAN ATTRACT METAL OBJECTS AND IMPAIR ELECTRONIC DEVICES. IF YOU HAVE ANY MAGNETIC OBJECTS ON OR IN YOUR BODY OR ANY ELECTRONIC DEVICES, THEY COULD BE DAMAGED OR CAUSE YOU HARM IF YOU ENTER THE SCANNER ROOM. THEREFORE, IT IS IMPORTANT THAT YOU ANSWER EACH QUESTION HONESTLY AND THOROUGHLY.**

A. A PATIENT WHO ANSWERS YES TO ANY OF THE FOLLOWING QUESTIONS MAY BE EXCLUDED FROM THE MRI STUDIES.

1. Have you ever worked with metal (grinding, fabrication, etc.) or ever had an injury to the eye involving a metallic object (e.g. metallic slivers, foreign body)? YES NO Was the metal object removed? YES NO

2. Please indicate if you have any of the following:

a. A cardiac pacemaker, implanted cardioverter defibrillator (ICD)	YES	NO	i. Vascular access port and or catheter	YES	NO
b. Eye Implants (prosthesis, retinal tack, eyelid wire or spring)	YES	NO	j. Neurostimulator system, spinal cord stimulator, bone growth/bone fusion stimulator	YES	NO
c. Radiation seeds or implants for cancer treatment or other treatments	YES	NO	k. Aneurysm clips	YES	NO
d. Electronic implant or devices	YES	NO	l. Any type of non removable pump (pain, drug infusion, insulin, etc.)	YES	NO
e. Magnetically activated implant or device	YES	NO	m. Ear implants (cochlear, otologic staples, prosthetic ear bone)	YES	NO
f. Internal electrodes or wires	YES	NO	n. Penile implant (for males)	YES	NO
g. Tissue expander	YES	NO			
h. Shunts (spinal or intra-ventricular)	YES	NO			

3. Are you pregnant or are you experiencing a late menstrual cycle? YES NO
   If yes or unsure the MRI study will be rescheduled until a negative pregnancy test is produced you the patient.

B. IF A PATIENT ANSWERS YES TO ANY OF THE FOLLOWING QUESTIONS, THEY MUST BE CLEARED TO PROCEED WITH THE MRI STUDY.

1. Have you ever been injured by an object or foreign body such as a BB, bullet, shrapnel or shard of metal? Have you ever been injured with metal that may still be left in your body? YES NO
   If yes, please describe: _____

2. Please indicate if you have any of the following:

a. Joint replacement (hip, knee, etc.)	YES	NO	g. Wire mesh implants	YES	NO
b. Bone/joint pin, screw, nail, wire, plate, etc.	YES	NO	h. Heart valve prosthesis	YES	NO
c. Surgical staples, clips, or metallic sutures	YES	NO	i. Any type of insulin pump	YES	NO
d. Artificial limb	YES	NO	j. Metallic stents, filters, or coils	YES	NO
. e. IUD (for females)	YES	NO	k. Tattoos on face or permanent cosmetics (e.g. eye or lip liner, etc.)	YES	NO
f. Other implant_____	YES	NO			

3. Do you experience claustrophobia? YES NO
4. Do you wear any medication patches (nicotine, nitroglycerine, contraceptives, pain)? YES NO

(OVER)

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C. THE FOLLOWING QUESTIONS ARE IN REGARD TO CONDITIONS THAT MAY AFFECT THE QUALITY OF THE MRI IMAGES.

1. Please indicate if you currently have any of the following:
   a. Braces, permanent retainer YES NO b. Hair weaves, wig, extensions and/or braids YES NO

D. BACKGROUND INFORMATION.

1. Have you ever had a prior study of the affected area (MRI, CT, ultrasound, x-ray, etc)? YES NO
   If yes, please list Facility
   MRI _____Other_____
2. Have you experienced any problem related to a previous MRI study? YES NO
   If yes, please describe_____
3. Please list all previous surgeries _____
   _____
4. Are you allergic to any medications? YES NO If yes, please list_____

E. IF A PATIENT ANSWERS YES TO ANY OF THE FOLLOWING, THEY ARE REQUIRED TO REMOVE THEM BEFORE ENTERING THE MRI SUITE.

1. Do you have any of the following?

a. Hearing aid	YES NO	d. Colored contacts	YES NO
b. Body piercing jewelry	YES NO	e. Removable dental work	YES NO
c. (For females) diaphragm, cervical ring	YES NO	f. Prescription eyewear	YES NO

F. REASON FOR MRI AND/OR SYMPTOMS:

_____

_____

_____

_____

How long have you had symptoms?_____

Is this the result of an injury? YES NO Date of Injury:_____

If injury, explain:_____

_____

Physical therapy for this problem? YES NO Date: _____

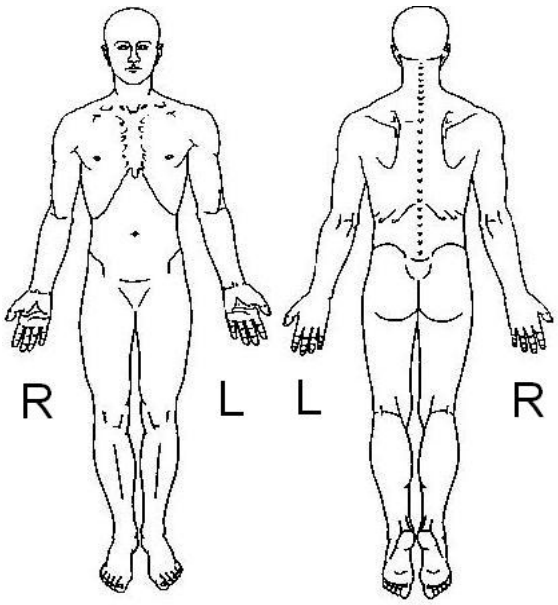
Cortisone injection for this problem? YES NO Date: _____

Prior surgery in area being scanned? YES NO Date: _____

_____

History of cancer? YES NO _____

Please indicate areas of pain on figures:



G. SIGNATURES: I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo.

_____ _____ _____

(Signature of Patient or Legal Guardian) (Form reviewed by) (Date)