KAISER PERMANENTE®

MRI SAFETY SCREENING FORM

MR# _____

Name_____

IMPRINT AREA

☐ Yes ☐ No Do you have any metal in your body? If yes, where: _____
☐ Yes ☐ No Do you have any metal on your body/clothing? If yes, where: _____
☐ Yes ☐ No Have you ever been injured by a metallic object or foreign body? (BB, bullet, shrapnel, etc.)
☐ Yes ☐ No Have you ever had an injury to the eye involving a metallic object or fragment in the eye?
☐ Yes ☐ No **Patients Only:** Claustrophobia Weight_____ Height _____
List any past surgeries/date: _____

The following items may be harmful to you during your MR scan or may interfere with the MRI examination. Please answer "yes" or "no" for every item.

YES	NO	
☐	☐	Heart pacemaker or implanted cardioverter defibrillator/ICD
☐	☐	Internal electrodes or wires (pacing wires, DBS or VNS wires)
☐	☐	Implanted drug pump (e.g., insulin, chemotherapy, pain medication)
☐	☐	Any IV Access port (Port-a-Cath, Broviac, PICC line, Swan-Gantz, Thermodilution)
☐	☐	Neurostimulator –Vagus Nerve(VNS), TENS Unit, Biostimulator, bone growth stimulator, DeepBrain
☐	☐	Artificial heart valve, coil, filter, stent . Date of implant:_____
☐	☐	Aneurysm clip/coil Date of implant:_____ Location: _____
☐	☐	Shunt; is it a ☐programmable/adjustable shunt or a ☐non-programmable shunt
☐	☐	Implanted post surgical hardware (pins, rods, screws, plates, wires, prosthesis, joint replacement)
☐	☐	Prosthesis of any kind (eye, ear, penile, limb)
☐	☐	Artificial eye and/or eyelid spring
☐	☐	Electronic implant/device or magnetically activated implant /device
☐	☐	Cochlear, other ear implant, or Hearing aid: *Remove prior to entering MRI room*
☐	☐	False teeth/dentures, partial plates, removable dental work, braces, retainer
☐	☐	Medication patch. What type:_____
☐	☐	Surgical clips, staples, mesh implants
☐	☐	Breast tissue expander
☐	☐	Pessary, IUD, diaphragm (currently in place)
☐	☐	Radiation seed or implants for cancer treatment
☐	☐	Body piercing jewelry, tattoos, permanent makeup
☐	☐	Wire mesh implants, wig, hair implants, hair clips or attachments.

FOR PATIENTS ONLY: Do you have a history of:

YES	NO		YES	NO	
☐	☐	Kidney disease or kidney surgery	☐	☐	Multiple myeloma, plasmacytoma, amyloidosis
☐	☐	Diabetes	☐	☐	Allergic reaction to MRI contrast?
☐	☐	High Blood Pressure	☐	☐	Any drug allergy. Type_____
☐	☐	Liver disease or liver surgery	☐	☐	Any organ transplant. Specify_____

Are you on dialysis? ☐Yes ☐No If YES, Hemodialysis or Peritoneal dialysis? (circle one)

FEMALE PATIENTS ONLY: __/__/____ Date of the start of your last menstrual period?
☐ Yes ☐ No Any possibility that you may be pregnant? ☐ Yes ☐ No Are you breastfeeding?

I attest that the above information is correct to the best of my knowledge. I have 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.

PATIENT SIGNATURE	DATE
PERSON COMPLETING THE FORM /RELATIONSHIP TO PATIENT	TECHNOLOGIST INITIALS:

FOR YOUR SAFETY, PLEASE REVIEW THE FOLLOWING ITEMS IN DETAIL:

- ✓ **Certain clothing can have metal fibers that may be hazardous to you in the MRI environment.**
- ✓ **Certain implants, devices, or objects may be hazardous to you in the MRI environment.**
- ✓ **Do not enter the MRI Room if you have any question or concern regarding an implant, device, or object.**
- ✓ **Please consult the MRI Technologist if you have any questions or concerns BEFORE you enter the MRI system room.**

IMPORTANT INSTRUCTIONS

Please secure your belongings! A locker may be provided so ALL items you remove may be stored and locked safely during your scan.

1. Remove ALL jewelry and ALL body piercing jewelry and ALL hair accessories.
2. Remove dentures, false teeth, partial dental plates, retainers, if imaging the head face or neck region.
3. Remove hearing aids and eyeglasses.
4. Please empty ALL pockets of ALL items you may be carrying.
5. Remove ALL clothing with metal fiber, fasteners, snaps, zippers and remove your belt.
6. Secure all your belongings (clothes, shoes, wallet, keys, cell phone, electronics and valuables).
7. Please use the restroom before your MRI exam.
8. Please make sure that you receive a pair of earplugs before your MRI exam begins.

If you answered yes to any of the questions on the MRI Safety Screening Form, please discuss those answers with the technologist prior to your exam.

FOR HOSPITAL INPATIENTS: **(to be completed by RN)**	
☐ Yes ☐ No Oxygen needed? ☐ Yes ☐ No Medications needed? ☐ Yes ☐ No Existing IV?	☐ Yes ☐ No Able to lie still for longer than 30 minutes? ☐ Yes ☐ No Able to lie still on back (supine)? ☐ Yes ☐ No Any contact disease (ie: MRSA)? ☐ Yes ☐ No Able to cooperate

PATIENT QUESTIONNAIRE: Please answer any questions that apply.

When patient arrives, they should be in non-metallic gowns (ie shoulder snap). If not, patient care may be delayed.

Reason for scan: _____

Did you injure yourself? When? How? _____

What and where are your symptoms? _____

How long have you had this problem(s)? _____

Is it getting better? Worse? _____

What treatments, if any, have you had? _____, (ex: surgery, injections) When? _____

If you answered yes to any questions on page 1, please indicate type and date of placement below:

Type_____ Date of Placement _____

Type_____ Date of Placement _____

Type_____ Date of Placement _____

What other imaging studies related to your current problem have you had? _____

When and where? _____

Other Comments: _____

I attest that the above information is correct to the best of my knowledge. I have 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.

PATIENT SIGNATURE	DATE
PERSON COMPLETING THE FORM (IF DIFFERENT FROM PATIENT)	PRINT NAME/RELATIONSHIP TO PATIENT