



MRI Screening Form

Patient Na	ame:		Height	Weight	
(please check) YES NO		For SAFETY reasons, please answer the following questions			
		Pacemaker, heart valve, stent, filter, nitro pa	tch, or other ca	rdiac implants (circle)	
		Have you ever had brain surgery?			
		Do you have aneurysm clips in the brain?			
Have you ever had surgery on the eyes			or inner ears?		
Do you have metal in your eyes?					
	Have you ever worked with cutting, grinding, or welding metal?			tal?	
	Do you have any implanted devices in your body? (pain pump, insulin pump, bone growth stimulator, tens unit, penile implant, etc) please list				
	Do you wear hearing aids? (Please remove prior to MRI)				
		Do you have tattooed eyeliner, body piercing (please circle)			
		Do you have metal in your body? (shrapnel, implanted rods, pins, plates, screws, IUB, et		d, surgically	
		Do you wear removable dental work? (may	need to be rem	noved)	
(please check) YES NO		For CLINICAL reasons, please answe	r the followir	ng questions	
		Are you possibly pregnant? Or nursing?			
		Have you ever been diagnosed with cancer?	•		
	Do you have anemia, sickle cell anemia, or hemolytic anemia?				
		Do you have any kidney disease or renal fail	ure?		
your exam. occur in less	This agent is than 1% of and the injection	nay need to inject a special image enhancement agent is safe; however, a small number of patients may experients. A medication guide is available on request. on of Gadolinium if necessary. I hereby certify that the	erience headach I have read and	es, nausea or vomiting. Serious reactions understand the above. I give consent for	
Patient or Guardian Signature				Date	
TECHNOLO	GIST NOTE	ES: (Must note signs/symptoms, history and scan perf	ormed)	10cc of PH / MH	
				Unless specified above	
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Date: ___

Technologist Signature _____