MRI SAFETY SHEET

LEXINGTON DIAGNOSTIC CENTER & OPEN MRI

The following items can interfere with MR imaging and some may be unsafe for scanning. Have you ever had any of the following? Please circle Yes or No.

Yes	No	Cardiac pacemaker?
Yes	No	Implanted cardiac defibrillator(ICD)?
Yes	No	Aneurysm clips?
Yes	No	Electronic implant or device?
Yes	No	Magnetically-activated implant or device?
Yes	No	Neurostimulation system?
Yes	No	Spinal cord stimulator?
Yes	No	Insulin or infusion pump?
Yes	No	Implanted drug infusion device?
Yes	No	Bone growth/fusion stimulator?
Yes	No	Cochlear, otologic, or other ear implant?
Yes	No	Have you had metal fragments in your eyes that required medical attention? *
Yes	No	Any type of prosthesis (eye, penile, etc.)?
Yes	No	Other metallic implants?_____
Yes	No	Shrapnel, bullet, or pellet wounds?
Yes	No	Heart valve replacement or repair?
Yes	No	Electrodes or wires (inside body or on body)?
Yes	No	Intravascular stents, filters, or coils?
Yes	No	Shunt (spinal or intraventricular)?
Yes	No	Vascular access port and/or catheter?
Yes	No	Radiation seeds or implants?
Yes	No	Swan-Ganz or thermodilution catheter?
Yes	No	Any implant held in place by a magnet? _____
Yes	No	Medication patch (Nitroglycerin, nicotine)?
Yes	No	Hearing aid (remove before entering MR scan room)?
Yes	No	Tattoo or tattooed makeup (eyeliner, lips, etc.)?
Yes	No	Body piercing(s)? _____
Yes	No	Any metallic fragments or foreign bodies? _____
Yes	No	Wire sutures, surgical staples or clips?
Yes	No	Artificial limb or joint replacement? _____
Yes	No	Bone/joint pin, screw, nail, wire, plate? _____
Yes	No	IUD, diaphragm or pessary?
Yes	No	Metallic or wire mesh implants?
Yes	No	Tissue expander (e.g. breast)?
Yes	No	Dentures or partial plates?
Yes	No	Eye implants?
Yes	No	Eyelid spring or wire?

Please answer the following questions:

Yes	No	Are you pregnant?
Yes	No	Are you breast-feeding?
Yes	No	Over the age of 60?

Do you have or have you EVER had:

Yes	No	Kidney disease?
Yes	No	High blood pressure?
Yes	No	Diabetes?

Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, and clothing with metal in the material.

Receptionist initials _____

Clinical initials _____

*** *Staff Only:***

If patient answers **yes** to having metal fragments in their eyes, ask the following questions:

A. Were you told by your doctor that the metal was completely removed from your eye or eyes at that time? Yes No

B. If not, have you had a subsequent eye exam by an ophthalmologist and was the exam normal? Yes No

Patient's Printed Name: _____

Signature of Patient _____ Date _____

Signature of Parent or Guardian _____ Date _____

If another person filled out this form, name _____ Relation to patient _____

Interpreter (Circle one) In person / Telephone Name _____ Language _____

[Patient confirmation sign/date if required] _____ _____