

## MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM

(Please Print)

**WARNING: The MR system magnet is ALWAYS on. Certain implants, devices, or objects may be hazardous to you and/or may interfere with the procedure. Before entering the MR environment or room, you must remove all metallic objects. Please consult the technologist, nurse or radiologist and do not enter the MR environment or room if you have any questions or concerns.**

Please indicate if you have any of the following:

- Cardiac Pacemaker**  Yes  No      **Aneurysm clip(s)**  Yes  No  
**Nephrogenic Systemic Fibrosis**  Yes  No  
**Implanted cardioverter defibrillator (ICD)**  Yes  No      **Electronic device (e.g. deep brain/spinal cord stimulator)**  Yes  No

**If yes, stop here and contact a member of the Radiology staff**

If yes is checked on any of the following, a member of the Radiology staff will evaluate to ensure the appropriateness of the examination.

- Do you have trouble breathing when lying flat for a prolonged period?  Yes  No  
 Do you have pain that will prevent you from lying flat for a prolonged period?  Yes  No  
 Are you claustrophobic?  Yes  No  
 Do you have history of chronic kidney disease?  Yes  No  
 Are you currently on kidney dialysis?  Yes  No  
 Are you pregnant?  Yes  No  Unsure  Male  
 Are you breastfeeding?  Yes  No  N/A  
 Vascular access port and/or catheter  Yes  No      Swan-Ganz or thermodilution catheter  Yes  No  
 Wire mesh implant  Yes  No      Magnetically-activated implant or device  Yes  No  
 Bone growth/bone fusion stimulator  Yes  No      Radiation seeds or implant  Yes  No  
 Any metallic fragment or foreign body  Yes  No      Internal electrodes or wires  Yes  No  
 Medication patch (Nicotine, Nitroglycerine)  Yes  No      Cochlear, otologic, or other ear implant  Yes  No  
 Any type of prosthesis (eye, penile, etc.)  Yes  No      Insulin or other drug infusion  Yes  No  
 Eyelid spring or wire  Yes  No      Heart valve prosthesis  Yes  No  
 Shunt (spinal or intraventricular)  Yes  No      Surgical staples, clips, or metallic sutures  Yes  No  
 Hearing aid  Yes  No      Tissue expander (e.g., breast)  Yes  No  
 IUD, diaphragm, or pessary  Yes  No      Joint replacement (hip, knee, etc.)  Yes  No  
 Bone/joint pin, screw, nail, wire, plate, etc.  Yes  No      Other implant \_\_\_\_\_  Yes  No  
 Denture or partial plates      Yes  No       Tattoo or permanent makeup  Yes  No  
 Body piercing jewelry  Yes  No

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

Signature of person completing form: \_\_\_\_\_ Date: \_\_\_\_\_

Form Completed By:  Patient  Relative  Physician  Other \_\_\_\_\_  
Print Name Relationship to patient

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_  
Signature & Title Signature & Title Date

