Barton Medical Imaging

MRI SAFETY SCREENING FORM

Date: _____Name: _____ MRN#:_____

Female [ ] Male [ ] Age: _____ DOB: _____ Height: _____ Weight:_____

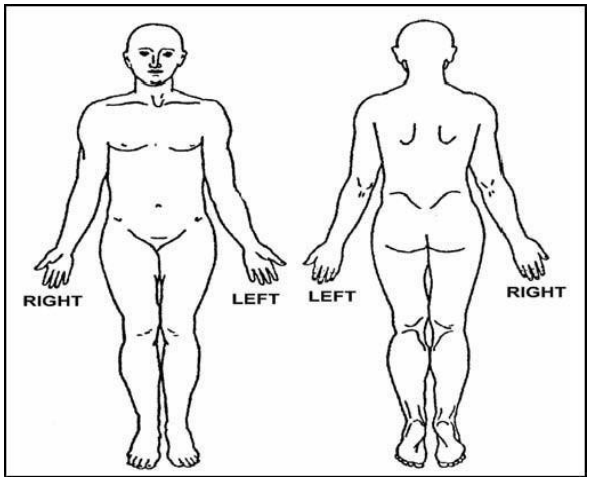
Instructions for all persons entering the MRI room:

- Remove all metallic, metal containing, and magnetic items
- Remove all jewelry (e.g. necklaces, bracelets, watches, pins, rings)
- Remove all hair pins, bobby pins, barrettes, clips, etc.
- Remove body piercing objects. If unable to remove you MUST notify MRI tech
- Remove all dentures, false teeth, partial dental plates
- Remove hearing aides
- Remove eyeglasses
- Remove pagers, cell phones, wallets, any credit/bank cards or any cards with a magnetic strip

The following questions will help identify items or conditions that may be harmful or may interfere with your MRI exam. You must circle YES or NO for every item. Please indicate if you have or have not had any of the following:

YES/NO: Have you ever been injured by a metal object or foreign body (e.g. BB, bullet, shrapnel)? If yes, please describe _____ _____ _____	**YES/NO**: Have you ever had a surgical operation or procedure of any kind including endoscopic or arthroscopic procedures? If yes, please list all prior surgeries and approximate dates: _____ _____ _____ _____ _____ _____
YES/NO: Have you ever had an injury from a metal object in your eye (metal sliver, metal shavings, other metal object)? **YES/NO**: If yes, did you seek medical attention? If yes, describe what was found _____ _____	

Please mark on the drawing indicating the location(s) of any metal inside your body or site of surgical operation(s)



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Do you have any of the following?

YES/NO: Any type of electronic, mechanical, or magnetic implant?

Type: _____

____ Cardiac pacemaker
____ Aneurysm clip
____ Implantable cardiac defibrillator (ICD)
____ Neurostimulator/biostimulator

Type: _____

____ Any type of internal electrode or wires
____ Cochlear implant
____ Hearing aide or any type of ear implant
____ Implanted/worn drug pump (e.g. insulin, baclofen, chemotherapy, pain medicine)
____ Halo vest/spinal fixation device
____ Spinal fusion procedure
____ Any type of vascular coil, filter, or stent (e.g. heart stent)

Type: _____

____ Artificial heart valve
____ Penile implant
____ Artificial eye
____ Eyelid spring/weight
____ Any type of implant held in place by a magnet

Type: _____

____ Any type of surgical clip or staple
____ Any surgical implant items (pins, plates, rods, screws, wires) _____
____ Artificial limb or joint? What and where _____
____ Surgical mesh? Location _____
____ Shunt
____ Any IV access port (e.g. Broviac, Port-a-Cath, Hickman, PICC line)
____ Medication patch (e.g. nitroglycerine, nicotine)
____ Tissue expander (e.g. breast)
____ Removable dentures, false teeth, or partial plates
____ Diaphragm, IUD? Type _____
____ Body piercing? Location(s) _____
____ Tattoos or tattooed eyeliner? Location of tattoo(s) _____
____ Wig, hair implants
____ Radiation seeds (e.g. cancer treatment)
____ Any other type of implanted device(s) not listed _____

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form, and I have had the opportunity to ask questions regarding the information on this form.

Patient signature/Date _____ MRI Tech signature/date: _____

Nurse signature/Date _____

Nurse/MRI tech will verify patient history with patient chart