



MRI Patient Screening

Patient information

Programmable Shunt	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pacemaker/Wires	<input type="checkbox"/> YES <input type="checkbox"/> NO
Internal Defibrillator	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cardiac implanted device monitor	<input type="checkbox"/> YES <input type="checkbox"/> NO
Stimulator/Wires	<input type="checkbox"/> YES <input type="checkbox"/> NO
Epidural/Swan Ganz catheter	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tissue Expander	<input type="checkbox"/> YES <input type="checkbox"/> NO
Surgical Clips	<input type="checkbox"/> YES <input type="checkbox"/> NO
Recent Stent Placement	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Vessel Coil	<input type="checkbox"/> YES <input type="checkbox"/> NO
Aneurysm Clips	<input type="checkbox"/> YES <input type="checkbox"/> NO
*Kidney Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
*Liver or Kidney Transplant	<input type="checkbox"/> YES <input type="checkbox"/> NO
*On Dialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO
*Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO
*Age _____ Weight (lbs): _____ Height: _____	

Cochlear Implant/Ear Implant	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tracheostomy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hearing Aid	<input type="checkbox"/> YES <input type="checkbox"/> NO
Penile Prosthesis	<input type="checkbox"/> YES <input type="checkbox"/> NO
IUD	<input type="checkbox"/> YES <input type="checkbox"/> NO
Eye Implants	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bullets, BBs, Pellets	<input type="checkbox"/> YES <input type="checkbox"/> NO
Medication Patch	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nicotine Patch	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Limb	<input type="checkbox"/> YES <input type="checkbox"/> NO
Infusion Pump	<input type="checkbox"/> YES <input type="checkbox"/> NO
History of Facial Injury	<input type="checkbox"/> YES <input type="checkbox"/> NO
Recent Endoscopy Procedure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pregnant or Breastfeeding	<input type="checkbox"/> YES <input type="checkbox"/> NO
Date of Last Menstrual Period _____ <input type="checkbox"/> N/A	
Other implanted metal or devices _____	

List all Allergies: _____ No Known Allergies

List all Surgeries: _____ No Known Surgeries

Part A Patient or Guardian
 I attest that the above information is correct. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form, for the MRI procedure that is about to be performed.
 Signature of Patient Guardian: _____ Date: _____
Signature

Part B Provider **If patient is not alert and oriented the provider must complete and sign**
 I attest that the above information has been confirmed and is verified by: Patients Family Sunrise/Hmed EPR
 Signature of Provider completing this form: _____ Provider ID number: _____ Date/Time: _____
Signature
 Provider's Contact number: _____

THIS SPACE IS FOR DEPARTMENT USE ONLY *Requires eGFR eGFR is: _____ Orbits: YES NO

Initial Reviewed By: _____ Date/Time: _____
Print Name Signature

Final Reviewed By: _____ Date/Time: _____
Print Name Signature