HDI
High Desert Imaging

MRI Safety Questionnaire

Patient Name: _____ **Date** _____

Weight:_____**Height:**_____ **DOB:**_____**Sex (M/F) :**_____

PLEASE ANSWER ALL QUESTIONS *(Circle response for YES/NO questions)*

Describe your symptoms *(i.e., pain, numbness, headache, etc.)***:**

_____

_____

Were you injured in the area being examined? YES / NO

If YES, please explain how you were injured: *(i.e., fall, accident, lifting, etc.)*

_____

_____

_____

Have you had surgery in the area being examined? YES / NO If YES, when? *(Approximate year)* _____

Is it possible you may have metal in your eyes? YES / NO

Have you ever had cancer? YES / NO If YES, what type?_____

Do you have any blood disorders, renal disease, or seizures? YES / NO

If YES, please describe: _____

Have you ever had an MRI? YES / NO If YES, on what body part? _____

Do you have any drug allergies? YES / NO

If YES, please list: _____

Do you smoke? YES / NO

Are you diabetic? YES / NO

Are you pregnant or experiencing a late period? YES / NO

Are you breast feeding? YES / NO

Please list all the studies you may have had recently that might pertain to the body part being examined today:
(i.e., X-rays, MRIs, Cat Scans, etc.)

_____

_____

_____

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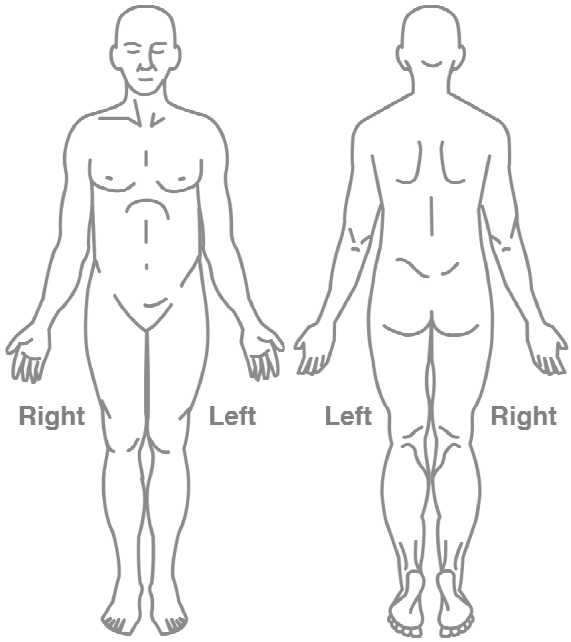
WARNING: Certain implants, devices, or objects may be hazardous to you and or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **DO NOT ENTER** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Radiologic Technologist **BEFORE** entering the MR system room. The MR system magnet is ALWAYS on.

Please circle YES or NO if you have any of the following:

Aneurysm clip(s)	**YES / NO**
Cardiac pacemaker	**YES / NO**
Implanted cardioverter defibrillator *(ICD)*	**YES / NO**
Electronic implant or device	**YES / NO**
Magnetically-activated implant or device	**YES / NO**
Neurostimulation system	**YES / NO**
Spinal cord stimulator	**YES / NO**
Internal electrodes or wires	**YES / NO**
Bone growth/bone fusion stimulator	**YES / NO**
Cochlear, otologic, or other ear implant	**YES / NO**
Insulin or other infusion pump	**YES / NO**
Implanted drug infusion device	**YES / NO**
Any type of prosthesis *(eye, penile, etc.)*	**YES / NO**
Heart valve prosthesis	**YES / NO**
Eyelid spring or wire	**YES / NO**
Artificial or prosthetic limb	**YES / NO**
Metallic stent, filter, or coil	**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**
Medication patch *(Nicotine, Nitroglycerine)*	**YES / NO**
Any metallic fragment or foreign body	**YES / NO**
Wire mesh implant	**YES / NO**
Tissue expander *(i.e., breast)*	**YES / NO**
Surgical staples, clips, or metallic sutures	**YES / NO**
Joint replacement *(hip, knee, etc.)*	**YES / NO**
Bone/joint pin, screw, nail, wire, plate, etc.	**YES / NO**
IUD, diaphragm, or pessary	**YES / NO**
Dentures or partial plates	**YES / NO**
Tattoo or permanent makeup	**YES / NO**
Body piercing jewelry	**YES / NO**
Hearing aid *(remove before entering MR system room)*	**YES / NO**
Other implant:	**YES / NO**
Breathing problem or motion disorder	**YES / NO**
Claustrophobia	**YES / NO**

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment/MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners and clothing with metallic threads.

Please consult the MRI Radiologic Technologist if you have any questions or concerns BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

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

Form Completed By *(Please print name)*: _____

Relationship to Patient: ❑ **Patient** ❑ **Relative** ❑ **Nurse** ❑ **Other** _____

Signature of Responsible Party: _____ **Date** _____

FOR INTERNAL USE ONLY Form Reviewed By: ❑ MRI Tech ❑ Radiologist ❑ Other _____

Approved by *(signature)* **:** _____