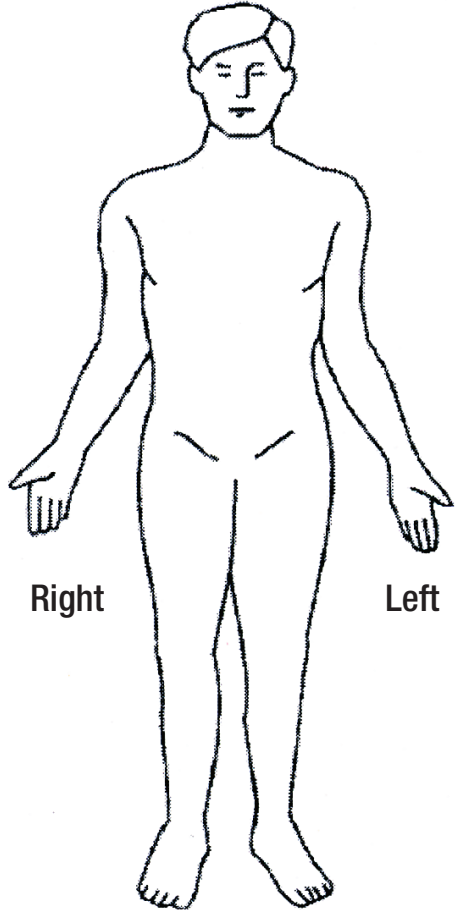


MRI Patient Screening Form

Patient Name: _____	Date: <u> </u> / <u> </u> / <u> </u>																																																																																										
Date of Birth: <u> </u> / <u> </u> / <u> </u>	Weight: _____																																																																																										
<p>The following items may interfere with MR imaging and be hazardous to your safety. Please indicate with a (✓) check mark if you have any of the following:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 10%; text-align: center;">YES</th> <th style="width: 10%; text-align: center;">NO</th> </tr> </thead> <tbody> <tr><td>Cardiac pacemaker</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Pacing wires (from previous pacemaker)</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Cerebral aneurysm clips</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Neuro or bio stimulator device</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Swan Ganz line (or metallic wire/tip catheter)</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Implanted insulin/chemotherapy pump</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Cochlear (middle ear) implant</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Heart valve replacement</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Hearing aid</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Orbital/eye prosthesis (cataract lens implant safe)</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input 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Is this a Workplace Safety and Insurance Board Claim (WSIB)? <input type="checkbox"/> No <input type="checkbox"/> Yes... Claim # _____	
Patient Signature: _____	Date: <u> </u> / <u> </u> / <u> </u>
Substitute Decision-Maker Name: _____	Date: <u> </u> / <u> </u> / <u> </u>
Technologist Name: _____	Date: <u> </u> / <u> </u> / <u> </u>

