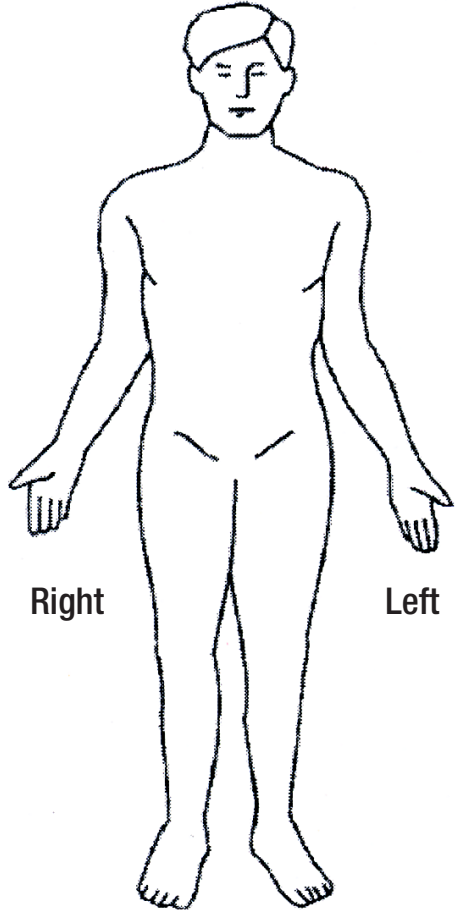


MRI Patient Safety Screening Form

Patient Name: <i>(print first, last)</i> _____		Date: <u> </u> / <u> </u> / <u> </u>																																																																											
Date of Birth: <u> </u> / <u> </u> / <u> </u>	Height: _____	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 border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></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 (inner 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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center;"><input type="checkbox"/></td></tr> <tr><td>Do you have a history of Kidney Disease?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Are you on Dialysis?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table>				YES	NO	Cardiac pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Pacing wires (from previous pacemaker)	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral aneurysm clips	<input type="checkbox"/>	<input type="checkbox"/>	Neuro or bio stimulator device	<input type="checkbox"/>	<input type="checkbox"/>	Swan Ganz line (or metallic wire/tip catheter)	<input type="checkbox"/>	<input type="checkbox"/>	Implanted insulin/chemotherapy pump	<input type="checkbox"/>	<input type="checkbox"/>	Cochlear (inner ear) implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart valve 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Patient Signature: _____	Date: <u> </u> / <u> </u> / <u> </u>
Substitute Decision-Maker Name: <i>(print first, last)</i> _____	Date: <u> </u> / <u> </u> / <u> </u>
Technologist Name: <i>(print first, last)</i> _____	Date: <u> </u> / <u> </u> / <u> </u>