HOUSTON Methodist LEADING MEDICINE

Radiology-MRI Department

MRI Safety Questionnaire Form

MRI Departmental Form / Revised 02-2015

01. Do you have any of the following:

HEART PACEMAKER / DEFIBRILLATOR	Y __	N __	METAL INJURY TO EYE(S) /BODY	Y __	N __
DEEP BRAIN STIMULATOR	Y __	N __	COCHLEAR (INNER EAR) IMPLANTS	Y __	N __
SPINAL CORD STIMULATOR	Y __	N __	TISSUE EXPANDER	Y __	N __
VAGAL NERVE/ BLADDER STIMULATOR	Y __	N __	PILLCAM (Endoscopic camera pill w/in 30 days)	Y __	N __

IF you have selected YES to any of the questions above. Please inform MRI personnel IMMEDIATELY

02. Pregnant or suspect pregnancy? Y __ N __ **03. Date of last menstrual cycle:** _____

04. Do you have any of the following:

Brain Aneurysm Clips (documentation required)	Y __	N __	Coil, Filter, Stents	Y __	N __
Shunt (programmable?)	Y __	N __	Implanted Pump (insulin, baclofen, chemo)	Y __	N __
Appointment with MD to reprogram programmable shunt or implanted Pump?				Y __	N __
Eyelid Spring	Y __	N __	Electronic / Mechanical Implant	Y __	N __
Artificial Eyes	Y __	N __	Bone Stimulator	Y __	N __
Ear Implant	Y __	N __	Shrapnel, Bullet, BB	Y __	N __
Hearing Aids	Y __	N __	Implants Held by Magnets	Y __	N __
Removable Dentures / Partial Plates	Y __	N __	Miscellaneous Implant(s)	Y __	N __
Internal Electrodes or Wires	Y __	N __	Tattoos / Tattooed Eyeliner	Y __	N __
Artificial Limbs / Joints (prosthesis)	Y __	N __	Body Piercing	Y __	N __
Halo Vest / Spinal Fixation Device	Y __	N __	Radiation Seeds	Y __	N __
Surgical Clips or Skin Staples	Y __	N __	Medication Patch	Y __	N __
Implanted Items (pins, screws, rods, etc)	Y __	N __	Penile Implant	Y __	N __

05. In your own words, what made your doctor order this MRI today?_____

_____

06. Have you ever had a surgical operation or procedure? Y __ N __ **If yes, list surgeries:**_____

_____

07. (a) Have you had an MRI examination before? Y___ N___

(b) Did you experience any problems? Y___ N___ If Yes, please explain:_____

08. What is your approximate weight _____lbs _____Kilos

_____ _____

Patient Signature **Date**

_____(_____) _____

Parent / Guardian Signature **Relationship** **Date**

FOR MRI OFFICE USE ONLY

_____

MRI Safety Qualified Representative Signature
Preliminary Review – Level 1 or 2 Personnel

_____

MRI Safety Qualified Representative Signature
Final Review – Level 2 Only

☐ Phone Assessment ☐ Phone number

☐ Date _____ ☐ RT initials _____ ( )_____

ADHERE PATIENT LABEL WITHIN THIS AREA