



**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__

**STOP** 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**