RADSCR

Montefiore

MAGNETIC RESONANCE IMAGING SAFETY SCREENING FORM

PATIENT LABEL

DATE:_____ TIME:_____ WEIGHT:_____

YES	NO	PLEASE CHECK. ALL QUESTIONS MUST BE ANSWERED.
☐	☐	Have you EVER had a pacemaker/defibrillator/ ICD/AICD? (Implantable Cardioverter Defibrillator / Automatic Implantable Cardioverter Defibrillator)
☐	☐	Have you EVER had an Electrical/Nerve/Spinal/Bone Stimulator?
☐	☐	Do you use hearing aids?
☐	☐	Have you EVER had a cochlear implant?
☐	☐	Have you ever been told you have kidney disease? If yes, please specify: _____
☐	☐	Are you currently receiving dialysis?
☐	☐	Have you ever been a machinist, welder or metal worker?
☐	☐	Have you had metal removed from your eyes?
☐	☐	Have you been shot with bullets, BBs, or shrapnel?
☐	☐	Any surgery? If yes, please specify: OPERATION: DATE:
		_____ _____
		_____ _____
☐	☐	Brain/Aneurysm clips
☐	☐	Ear Implants
☐	☐	Infusion pumps
☐	☐	Coils, catheters, filters or wires in blood vessels
☐	☐	Artificial heart valves
☐	☐	Magnetic dental implants
☐	☐	IUD
☐	☐	Tissue expander for future implants
☐	☐	Body piercing
☐	☐	Stents, filters, coils, shunts
☐	☐	Removable dental work such as bridges or dentures
☐	☐	Transdermal patches
☐	☐	Date of last menstrual cycle?_____ Are your pregnant?_____
☐	☐	Artificial limbs or joint replacement
☐	☐	Tattooed eyeliner/Permanent makeup
☐	☐	Any type of metal: rods, pins, screws, nails, plates, wires, mesh, or other

PATIENT SIGNATURE _____

PRINT NAME _____

LEVEL I MRI SCREENING

Screening Form Reviewed By:

Print Name / Title / Date & Time

MRI TECHNOLOGIST MUST BE NOTIFIED OF ALL YES RESPONSES IMMEDIATELY.

TECHNOLOGIST'S USE ONLY

- I have reviewed the above form and made the following determination.

☐ No safety contraindication for MRI

☐ MRI contraindicated (exam canceled)

☐ Further clarification by the Radiologist: ☐ Approved ☐ Exam canceled

PRINT NAME/CREDENTIALS | SIGNATURE/CREDENTIALS | DATE/TIME

☐ Specific Precautions Will be Taken

PRINT NAME/CREDENTIALS | SIGNATURE/CREDENTIALS | DATE/TIME