

MRI Screening Form

Magnetic Resonance Imaging (MRI) uses a very strong magnetic field that is **always on**. It may be dangerous for people to enter the environment with certain metallic, electronic, magnetic, mechanical implants, devices or objects. Please answer the following questions carefully and accurately. If you have any questions please speak with the MRI technologist.

Name	Date of Birth (DD/MMM/YYYY)	Height	Weight
1. Have you ever worked with metal in any way (grinding, welding, metal work)? Y <input type="checkbox"/> N <input type="checkbox"/>			
2. Have you ever had a piece of metal penetrate your eye? (If yes to 1&2, orbital x-ray required) Y <input type="checkbox"/> N <input type="checkbox"/>			
3. Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel, etc.)? Y <input type="checkbox"/> N <input type="checkbox"/>			
If yes, please describe: _____			
4. Could you be pregnant? Y <input type="checkbox"/> N <input type="checkbox"/>			
5. Are you claustrophobic? Y <input type="checkbox"/> N <input type="checkbox"/>			
6. Have you had a previous MRI? If yes, please describe any problems experienced Y <input type="checkbox"/> N <input type="checkbox"/>			
Describe: _____			
7. Have you had any previous surgery or invasive procedure? (e.g. heart, head, eye, or orthopedic) Y <input type="checkbox"/> N <input type="checkbox"/>			
Describe: _____			

Please indicate if you have any of the following:

Pacemaker or pacing wires	Y <input type="checkbox"/> N <input type="checkbox"/>	Artificial or prosthetic limb/joint	Y <input type="checkbox"/> N <input type="checkbox"/>
Surgical aneurysm clip(s)	Y <input type="checkbox"/> N <input type="checkbox"/>	Orthopedic rods, plates, screws, wires	Y <input type="checkbox"/> N <input type="checkbox"/>
Cochlear implant or hearing device	Y <input type="checkbox"/> N <input type="checkbox"/>	Surgical clips, staples, wires	Y <input type="checkbox"/> N <input type="checkbox"/>
Implanted cardioverter Defibrillator (ICD)	Y <input type="checkbox"/> N <input type="checkbox"/>	Cardiovascular catheters	Y <input type="checkbox"/> N <input type="checkbox"/>
Heart valve	Y <input type="checkbox"/> N <input type="checkbox"/>	Electronic device implant	Y <input type="checkbox"/> N <input type="checkbox"/>
Intravascular coil, filter, clip or stent	Y <input type="checkbox"/> N <input type="checkbox"/>	Insulin or infusion pump	Y <input type="checkbox"/> N <input type="checkbox"/>
Ventriculoperitoneal (VP) shunt	Y <input type="checkbox"/> N <input type="checkbox"/>	Neurostimulator	Y <input type="checkbox"/> N <input type="checkbox"/>
Ear tubes (myringotomy)	Y <input type="checkbox"/> N <input type="checkbox"/>	Medication Patch	Y <input type="checkbox"/> N <input type="checkbox"/>
Prosthetic eye	Y <input type="checkbox"/> N <input type="checkbox"/>	G tube/ C tube/ J tube/ gastric button	Y <input type="checkbox"/> N <input type="checkbox"/>
Hearing Aids	Y <input type="checkbox"/> N <input type="checkbox"/>	Intra uterine Device (IUD)	Y <input type="checkbox"/> N <input type="checkbox"/>
Tattoo or body piercings	Y <input type="checkbox"/> N <input type="checkbox"/>	Dental implants / dentures / braces	Y <input type="checkbox"/> N <input type="checkbox"/>

Other implants: _____

I affirm that I have answered the questions to the best of my knowledge and consent to the MRI examination.

Form completed by: Participant Parent/Guardian Other

Name: _____ Signature: _____ Date: _____

Technologist (sig.): _____

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