The Orthopaedic & Fracture Clinic

MRI PATIENT HISTORY AND SAFETY SCREENING

Patient's Name / DOB: _____

MRI has a **strong magnetic field**, so the following items may be harmful or interfere during your MRI exam.

**** NOTE: Incomplete / Incorrect answers may lead to life-threatening situations ****

YES	NO	
☐	☐	**Pacemaker / Automatic Internal Cardiac Defibrillator**
☐	☐	**Brain Aneurysm Clips**
☐	☐	**Cochlear / Inner Ear Implants**
☐	☐	**LINX Ring (Reflux)**
☐	☐	**Neurostimulators / Bone Fusion Stimulators**

NOTE: If you have checked YES to any of the above boxes, you are ***NOT*** *a candidate for MRI @ OFC*

☐ ☐ **Have you ever had an injury to the eye involving a metallic object, foreign body or sheet metal injury?**
If YES, please describe**:**_____
NOTE: IF YES (even if it's been removed), an x-ray of the eyes must be taken and the report sent to MRI @ OFC

☐ ☐ CLAUSTROPHOBIA: **If YES, will patient be medicated?** ☐ Yes ☐ No
☐ ☐ Anaphylactic Reaction
☐ ☐ Allergic Reaction to IV Contrast Injection
☐ ☐ Drug allergies: **If YES, please describe**: _____
☐ ☐ Allergies – List: _____
☐ ☐ Asthma: **If YES, were pre-medication orders given?** ☐ Yes ☐ No

HEIGHT: _____

WEIGHT: _____

☐ ☐ Diabetes – **Type I** or **II** (Please circle) **If Yes, Insulin Dependent?** ☐ Yes ☐ No
☐ ☐ Cancer: **If YES, please describe** _____
☐ ☐ Kidney Disease
☐ ☐ Dialysis
☐ ☐ Feraheme Iron Injection –Date of last injection: _____
☐ ☐ Internal or External Drug Infusion / Insulin Pump

☐ ☐ Intra-vascular Coils, Filters, Stents (# stents _____)
☐ ☐ Intra-ventricular Shunts
☐ ☐ Vascular Access Port
☐ ☐ Bullets, Shrapnel, BB's – Location: _____
☐ ☐ Electrodes (i.e. Holter Monitor, TENS unit)
☐ ☐ Medication Patch – Location: _____
☐ ☐ Pill Camera or pH Probe for stomach / intestine test

☐ ☐ Joint Replacement / Prosthesis / Artificial Limbs
☐ ☐ Harrington Rod
☐ ☐ Surgical wires, mesh, sutures, clips, staples, plates, screws

☐ ☐ Penile Implant
☐ ☐ ***Currently*** Pregnant / Breastfeeding (please circle)
☐ ☐ Breast Implant / Prosthesis / Tissue Expander
☐ ☐ IUD – Type: _____
☐ ☐ Dentures or Dental Implants
☐ ☐ Eye Prosthesis
☐ ☐ Hearing Aids
☐ ☐ Body Piercings – Location:_____

LIST ALL PREVIOUS SURGERIES (be specific)
Include SURGERY / DATE / SURGEON / LOCATION
_____
_____
_____
_____
_____
_____
_____
_____

If you answered yes to ANY of the above questions, or have any concerns, please consult the MR Technologist or Radiologist before you enter the MR environment.

_____ _____ _____
Patient's Signature *MRI Staff use only: (please initial when screening patient)* Date