MRI SAFETY PATIENT ASSESSMENT

3 P Q

Date of Service: _____

Patient Name: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

MRI Exam and Reason or Symptoms: _____

1. Have you had previous diagnostic imaging or study (MRI, CT, X-Ray, US) related to this exam?	☐ Yes	☐ No
2. Are you diabetic?	☐ Yes	☐ No
3. Hypertension (high blood pressure)?	☐ Yes	☐ No
4. Do you have or have you had cancer (past or present)?	☐ Yes	☐ No
If YES, what type of cancer and what year? _____		
5. Do you have allergies to medications, foods, latex, IVP dye, contrast media, history of asthma or hay fever? List: _____	☐ Yes	☐ No
6. Have you ever had metal shavings, grinding, slivers, or a foreign body in the eye?	☐ Yes	☐ No
If YES, was it removed?	☐ Yes	☐ No
7. Have you had an x-ray of the eye previously done?	☐ Yes	☐ No
8. Do you have any history of metal in your body (eye, head, ear, skin)?	☐ Yes	☐ No
Gunshot or BB Location: _____		
Shrapnel or IED Location: _____		
Metal implants from surgery Location: _____		
9. Have you had recent surgery or procedure in last 6 weeks? List: _____	☐ Yes	☐ No
_____		
10. Have you had surgery for:		
Heart Date: _____	☐ Yes	☐ No
Stents Date: _____	☐ Yes	☐ No
Brain, eye, or ear Date: _____	☐ Yes	☐ No
Back Date: _____	☐ Yes	☐ No
Coils or Filters Date: _____	☐ Yes	☐ No
Programmable Pumps (Insulin, Flowonix, Baclofen, Pain) Date: _____	☐ Yes	☐ No
Neuro-stimulators (Bone, Nerve, Bladder) Date: _____	☐ Yes	☐ No
Do you have any of the following:		
11. Implanted cardiac pacemaker, defibrillator, or pacing wires	☐ Yes	☐ No
12. Cerebral aneurysm clip(s) or cerebral coil(s)	☐ Yes	☐ No
13. External heart monitor, electrodes, loop recorder, or aortic clips	☐ Yes	☐ No
14. Cochlear or ear implants	☐ Yes	☐ No
15. Renal failure or currently on dialysis	☐ Yes	☐ No
16. Artificial heart valves *(please present the identification card from the company to MRI staff)*	☐ Yes	☐ No
17. Intravascular coil, filter, venous umbrella, or stent	☐ Yes	☐ No
18. Wire mesh implants, or hernia repair with mesh	☐ Yes	☐ No
19. Vascular access ports, picc lines, or catheter	☐ Yes	☐ No
20. Urinary bladder catheter (with a collection device)	☐ Yes	☐ No
21. Harrington rods, cages, or spacer (placed in the spine)	☐ Yes	☐ No
22. Metal: rod, pin, screw, nail, wire, plate, staples, or joint(s) replacements in the bones	☐ Yes	☐ No
23. Prosthesis (eye/orbital, penile, arm, leg, or other)	☐ Yes	☐ No
24. Body tattoo, tattooed eyeliner or eyebrows	☐ Yes	☐ No
25. Do you have any other health problems we have not addressed? _____		
_____		

Wheaton Franciscan Healthcare St. Francis
3237 South 16th Street
Milwaukee, WI 53215

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Female Patients Only:

26. Date of last menstrual period: ____/____/____
27. Is there a possibility that you could be pregnant? ☐ Yes ☐ No
28. Are you currently breastfeeding, nursing, or lactating? ☐ Yes ☐ No
29. Do you currently have an intrauterine device (IUD), or pessary, or bladder ring? ☐ Yes ☐ No
30. Are you currently post-menopausal? ☐ Yes ☐ No
31. Do you have breast tissue expanders? ☐ Yes ☐ No

BEFORE entering the MRI area, you MUST REMOVE ALL METALLIC OBJECTS including:

- Insulin pump
- Medication or nicotine patches
- Dentures or removable teeth
- Hearing aide(s)
- Jewelry
- Eyeglasses
- Clothing with metal fasteners or threads
- Cell phones and beepers
- Keys
- Watch
- Purse, wallet, money clip
- Coins
- Bobby pins, hair clips, hair pieces, wigs
- Bank cards, credit cards, and other store cards with magnetic strip on back
- Pocket knife
- Tools
- Nail clippers
- Body and ear piercings
- Pens
- All other metal objects

You will be REQUIRED to wear earplugs or other hearing protection during the MRI procedure.

Your signature below indicates that you have answered the above questions to the best of your knowledge. You have read the above instructions, and have been given an opportunity to ask questions about the MRI procedure and the use of IV contrast material called “Gedolinium”. It may be used for this procedure if ordered by your healthcare provider. You acknowledge these instructions and fully understand them.

Date: _____ Time: _____ Patient Signature: _____

Form completed by: ☐ Self ☐ Spouse ☐ Child ☐ Family Member: _____
☐ Authorized Representative/Agent ☐ Other: _____

Name of person completing form, if **not** the patient: _____

Phone number of person completing form: _____

Date: _____ Time: _____ Reviewed by MRI staff: _____

MRI / NURSING STAFF ONLY

Notes about the patient:

- ☐ Claustrophobic / Unable to lie flat
- ☐ Breathing / motion difficulty
- ☐ Oxygen
- ☐ Telemetry
- ☐ Tremors
- ☐ Eye injury with metal
- ☐ Orbits cleared
- ☐ Vent
- ☐ Stents
- ☐ Filters
- ☐ Coils
- ☐ Pacemaker / Defibrillator
- ☐ Capped IV
- ☐ Over 159 kg
- ☐ Unable to give consent
- ☐ Wheelchair
- ☐ Cart
- ☐ Bed
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

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