CORE ORTHOPAEDIC MEDICAL CENTER

MRI Patient Screening

For office use only
Exam: _____ MR#: _____

Name:_____ Date:_____

Age: _____ Weight: _____ Sex: ☐ Female ☐ Male Referring Physician: _____
Explain Reason for this MRI: _____
_____

Have you had a previous exam related to this problem? ☐ Yes ☐ No When: _____ Where: _____
Personal History of Cancer? ☐ Yes ☐ No Type: _____
List of Previous Surgeries: _____

Could you be pregnant? ☐ Yes ☐ No

MRI HAZARD CHECKLIST:	YES	NO		YES	NO
Any Electronic, Mechanical, or Magnetic Implant	☐	☐	Metal Injury to Eye	☐	☐
Cardiac Pacemaker	☐	☐	If yes, was it removed?	☐	☐
Aneurysm Clip	☐	☐	Any Implant Held by a Magnet	☐	☐
Implanted Cardiac Defibrillator	☐	☐	Any Surgical Clip or Staple	☐	☐
Neurostimulator	☐	☐	Any IV Access Port	☐	☐
Biostimulator	☐	☐	Medication Patch	☐	☐
Any Internal Electrode/Wire	☐	☐	Artificial Limb/Joint	☐	☐
Cochlear Implant	☐	☐	Shunt	☐	☐
Hearing Aid	☐	☐	Tissue Expander (e.g. breast)	☐	☐
Implanted Drug Pump	☐	☐	Removable Denture, Plate, Teeth	☐	☐
Halo Vest	☐	☐	Diaphragm, IUD, Pessary	☐	☐
Spinal Fixation Device	☐	☐	Body Piercing	☐	☐
Any Metal Object, Shrapnel, Bullett, BB	☐	☐	Hair Implants, Wig, Hair Extensions	☐	☐
Artificial Heart Valve	☐	☐	Tattoos or Tattooed Eyeliner	☐	☐
Ear Implant	☐	☐	Radiation Seeds	☐	☐
Penile Implant	☐	☐	Any Implanted Item (Rod, Screw, Pin)	☐	☐
Artificial Eye	☐	☐	Hair Accessories (Bobby Pins, Clips)	☐	☐
Eyelid Spring	☐	☐	Jewelry	☐	☐
Brain Surgery	☐	☐			

Have you previously had an MR scan performed? ☐ Yes ☐ No

If you have any jewelry on your feet, hands, or arms, please remove. Please remove all metal objects from your pockets and your person (i.e. jewelry, keys, belt/buckle, etc.)

I have answered all questions accurately. I understand that if the answers to the above questions are incorrect, that I may risk injury to myself from the MRI exam.

_____ _____
Signature of patient or responsible party Date Signature of staff verifying information Date