MRI Screening Form

BJC HealthCare

Patient Name _____ Date of Birth _____ Medical Record Number _____	* Document manufacturer/model in Comment Section Height: _____ Weight_____

Imaging MRI Screening - Please answer *all* questions

LIST ALL PAST SURGERIES (including orthopedic/joint pins, wires):

Cardiovascular Implantable Electronic Device, Pacemaker, or Implantable Cardioverter-Defibrillator	☐ YES* ☐ NO **Comment**	Implanted Drug Pump	☐ YES* ☐ NO **Comment**
Current or Retained Pacing Wires	☐ YES* ☐ NO **Comment**	Claustrophobic	☐ YES ☐ NO **Comment**
Loop Recorder or Heart Monitor	☐ YES* ☐ NO **Comment**	Pregnant - *If UNSURE and receiving MRI Contrast, you may need a pregnancy test*	☐ YES ☐ NO ☐ UNSURE
Artificial Heart Valve	☐ YES* ☐ NO **Comment**	Breastfeeding	☐ YES ☐ NO **Comment**
Cardiac Stents	☐ YES ☐ NO **Comment**	Diaphragm or IUD	☐ YES ☐ NO **Comment**
Eyelid Spring, Retinal Tacks, or Other Ocular Implant	☐ YES* ☐ NO **Comment**	Penile Implant	☐ YES* ☐ NO **Comment**
Cochlear or Other Ear Implant	☐ YES* ☐ NO **Comment**	Bladder Rings	☐ YES* ☐ NO **Comment**
Vascular Ports or Catheters	☐ YES* ☐ NO **Comment**	Allergy to MRI Contrast - *If YES, please document type of reaction to MRI Contrast in the comment section to the right.*	☐ YES ☐ NO **Comment**
Tattoos, Tattoo Eye or Lip Liner	☐ YES ☐ NO **Comment**	Kidney Disease	☐ YES ☐ NO **Comment**
Metal in Eye - *If YES, please alert MRI staff for further direction*	☐ YES ☐ NO **Comment**	Dialysis	☐ YES ☐ NO **Comment**
Metal REMOVED From Eye by MD - *If YES, orbit imaging is required to confirm there are no retained foreign bodies*	☐ YES ☐ NO **Comment**	Endoscopy Camera and/or Pill - *If YES, please document date that endoscopy camera or pill was swallowed.*	☐ YES ☐ NO **Comment**
Bullets, BBs, or Shrapnel - *If YES, please document date and location of bullet, BB, or shrapnel injury in the comment section to the right*	☐ YES ☐ NO **Comment**	Tissue Expanders - Breast or Other	☐ YES* ☐ NO **Comment**

Tracheotomy	☐ YES ☐ NO
	Comment
Brain Aneurysm Clip	☐ YES* ☐ NO
	Comment
Shunt	☐ YES* ☐ NO
	Comment
Neurostimulator	☐ YES* ☐ NO
	Comment
Diaphragmatic Stimulator	☐ YES* ☐ NO
	Comment
Deep Brain Stimulator	☐ YES* ☐ NO
	Comment
Vagus Nerve Stimulator	☐ YES* ☐ NO
	Comment
Bone Growth Stimulator	☐ YES* ☐ NO
	Comment
Spinal Cord Stimulator	☐ YES ☐ NO
	Comment
Any Other Biostimulator (In-place or Removed)	☐ YES* ☐ NO
	Comment
Orthopedic Fixation Devices (Screws, Rods, Pins, Plates)	☐ YES ☐ NO
	Comment
Any Other Implanted Metal or Device	☐ YES* ☐ NO
	Comment
Coils, Filters, or Stents	☐ YES* ☐ NO
	Comment

Wire Mesh or Metal Sutures	☐ YES* ☐ NO
	Comment

IMAGING MRI SCREENING - REMOVABLE ITEMS

Hearing Aid *If YES, remove item prior to entering MRI area.*	☐ YES ☐ NO
	Comment
Medication Patch *If YES, remove item prior to entering MRI area.*	☐ YES ☐ NO
	Comment
Artificial Limb Containing Metal or a Computer Chip *If YES, remove item prior to entering MRI area.*	☐ YES ☐ NO
	Comment
Artificial Limb Electronics *If YES, remove item prior to entering MRI area.*	☐ YES ☐ NO
	Comment
False Teeth or Partial Plate *If YES, remove item prior to entering MRI area.*	☐ YES ☐ NO
	Comment
Body Piercing *If YES, remove item prior to entering MRI area.*	☐ YES ☐ NO
	Comment
Wigs, Hair Implants, Clips or Pins *If YES, remove item prior to entering MRI area.*	☐ YES ☐ NO
	Comment
Insulin Pump *If YES, remove item prior to entering MRI area.*	☐ YES ☐ NO
	Comment
Glucose Monitoring Device *If YES, remove item prior to entering MRI area.*	☐ YES ☐ NO
	Comment
Other Removable or Wearable Devices *If YES, please alert MR staff to determine if device needs to be removed prior to entering MRI area.*	☐ YES ☐ NO
	Comment

COMMENTS:

Form filled out by: ☐ Patient ☐ Family ☐ Other: _____

_____	_____	_____
Patient/Representative Signature	Patient/Representative Printed	Date
_____	_____	_____
MRI Level II Staff Signature	MRI Level II Staff Printed	Date