



MRICKLST

MRI SCREENING FORM

****Some of the following items may be hazardous to your safety and some can interfere with the examination. Please check the correct answer for each of the following.****

Do you have any or ever had the following:

- Yes No Cardiac Pacemaker / Pacing Wires
- Yes No Implanted cardiac defibrillator (ICD)
- Yes No Brain Aneurysm Clip(s)/Brain Surgery
- Yes No Shunt (Spinal or Intraventricular)
- Yes No Intravascular Stent/Filter/Coil
- Yes No Neurostimulator/Bio stimulator
- Yes No Insulin/Infusion Pump
- Yes No Implanted drug infusion device
- Yes No Bone growth/fusion stimulator
- Yes No Cochlear/Stapes/Ear Implant or Surgery
- Yes No Any type of prosthesis (eye, penile, etc)
- Yes No Heart Valve Prosthesis/Heart Surgery
- Yes No Artificial limb or joint
- Yes No Joint Replacement _____
- Yes No Bone/Joint Pin/Screw/Nail/Wire/Plate
- Yes No Internal Electrodes (Body/Head/Brain)
- Yes No Vascular Access Port/Catheter
- Yes No Metal/Wire Mesh Implants
- Yes No Wire Sutures/Surgical Staples
- Yes No IUD/Diaphragm
- Yes No Gunshot Wound/Shrapnel/BB/metal fragments
- Yes No Electrical/Mechanical/Magnetic Implants
- Yes No Medication Patch
- Yes No Body Piercing (**MUST Remove before MRI**)
- Yes No Tattoo/Permanent Make-up
- Yes No **EVER** Done any grinding or welding
- Yes No Have any iron/metal/steel in eyes
- Yes No Hearing Aid (**MUST Remove before MRI**)
- Yes No Dentures (**May Need to Remove for MRI**)
- Yes No Diabetic
- Yes No Receiving Dialysis
- Yes No Renal/Kidney Failure/Transplant
- Yes No Have you ever had MRI contrast
- Yes No Did you have any type of reaction
- Yes No Have you taken any medication/alcohol for today's exam?
- Yes No If so, do you have a ride?
- Yes No Is there any chance you could be pregnant?
LMP _____

Patient's Name: _____

DOB: _____ Weight: _____ lbs

Patient Current Medication List

Not Currently Taking Medication

Patient Allergies

No Known Allergies

Patient Surgeries

Type/Date

No previous surgery

I attest that the above information is correct to the best of my knowledge. I understand the information presented to me. I also declare that to the best of my knowledge there is no chance that I may be pregnant, or is pregnancy suspected or confirmed at this particular time. I do not hold Arizona Spine & Joint Hospital, liable for this information I am providing.

Patient / POA Signature Date/ Time

Technologist Signature / Printed Name Date/ Time



PATIENT LABEL