CLEARVIEW DIAGNOSTIC
Focus Precision MRI Specialist

ACR AMERICAN COLLEGE OF RADIOLOGY

MRI SAFETY SCREENING QUESTIONNAIRE

PATIENT NAME: _____ **SEX:** _____ **AGE:** _____

HEIGHT: _____ **WEIGHT:** _____

The following items may be harmful to you during your MR Scan or may interfere with the MR examination. Please provide a "yes" or "no" answer for every item?

YES NO

- ☐ ☐ Cardiac pacemaker or implanted cardioverter defibrillator/ICD
- ☐ ☐ Internal electrodes or wires (pacin wires, DBS OR VNS wires)
- ☐ ☐ Artificial hearth value, coil, filter and/or stent (Gianturco coil, IVC filter)
- ☐ ☐ Aneurysm clip(s)
- ☐ ☐ Neurostimulator-TENS Unit, Biostimulator, bone growth stimulator, DBS, VNS
- ☐ ☐ Implanted drug pump (e.g., insulin, chemotherapy, pain medicine)
- ☐ ☐ IV access prot (Port-a-Cath, Broviac, PICC line, Swan-Gantz, Thermodilution)
- ☐ ☐ Implanted postsurgical hardware (pins, rods, screws, plates, wires)
- ☐ ☐ Artificial joint and/or limb
- ☐ ☐ Artificial eye and/or eyelid spring
- ☐ ☐ Eye injury from a metal object (metal shavings, metal slivers)
- ☐ ☐ Ear (cochlear) implant, middle ear implant
- ☐ ☐ Hearing aid(s)
- ☐ ☐ False teeth/dentures, metallic removable dental work, braces, retainers.
- ☐ ☐ Any type of implant held in place by a magnet.
- ☐ ☐ Injured by a metal object (shrapnel, bullet, BB) and required medical attention
- ☐ ☐ Medication patch (nitroglycerine, nicotine, contraceptive, estrogen)
- ☐ ☐ Shunt or Sophy adjustable and programmable pressure valve
- ☐ ☐ Spinal fixation device, spinal fusion and/or halo vest, spinal cord stimulator
- ☐ ☐ Surgical clips, stables or surgical mesh
- ☐ ☐ penile implant
- ☐ ☐ Pessary, IUD, Diaphragm
- ☐ ☐ Radiation seeds (cancer treatment)
- ☐ ☐ Body piercing, tattoo or permanent makeup
- ☐ ☐ Wig, hair implants

Do you have a history of:

YES NO Kidney diseases

YES NO High blood pressure

YES NO Congestive heart failure

YES NO Liver disease (Gadolinium based, Feridex)

YES NO Claustrophobia

YES NO Latex Allergy

YES NO Allergic reaction to MRI Contrast

YES NO History of Cancer, if yes, Type: _____

Are you on dialysis? YES NO If YES, Hemodialysis or Peridialysis? (Circle one)

Do you use Non-steroidal anti-inflammatory drugs on daily basis? YES NO

CLEARVIEW DIAGNOSTIC
Focus Precision MRI Specialist

ACR AMERICAN COLLEGE OF RADIOLOGY

MRI SAFETY SCREENING QUESTIONNAIRE

Female Patients:

Are you pregnant? ☐YES ☐NO

Are you breastfeeding? ☐YES ☐NO

If you are still menstruating, please provide the date of your las period: _____

If you answered **YES** to any of the questions on the front page, please discuss any concerns and/or issues you may have, with you MR Technologist.

Instructions for the Patient, Guardian:

We will provide a locker so **ALL** items you remove may be stored and locked safely during your scan. You may bring the key in the scan room with you.

1. Remove **ALL** jewelry and **ALL** body piercing jewelry and **ALL** hair accessories.
2. Remove dentures, false teeth, partial dental plates, retainers.
3. Remove hearing aids and eyeglasses.
4. Please empty **ALL** pockets of **ALL** items you may be carrying
5. Remove **ALL** clothing with metal fasteners, snaps, zippers and remove your belt.
6. Lock your clothes and valuables in the locker provided and remove the key.
7. Please use the restroom before your MRI exam.
8. Please make sure that you receive a pair of earplugs and/or the headphones before your MRI exam begins. Some patients may find the noise levels unacceptable, and the noise levels may affect your hearing.

I attest the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

✖ _____ ✖ _____ ✖ _____

Patient/parent/Guardian/Other Signature | Date | Time

_____ _____ _____

MR Tech/Signature | Date | Time

_____

Print Name of MR Tech

FOR MRI STAFF USE ONLY

CONTRAST ORDER/SIGNATURE **To Be Filed in the Medical Record**

CONTRAST TYPE: _____ INJECTION RATE: _____ INJECTION AMOUNT: _____

CREATININE VALUE: _____ GFR VALUE: _____ BUN VALUE: _____ DATE ACQUIRED: _____

CREATININE/GFR SCREENING WAIVED BY: _____

MRI TECHNOLOGIST SIGNATURE: _____ DATE: _____ TIME: _____

RADIOLOGIST SIGNATURE: _____ DATE: _____ TIME: _____