



ST. LUKE'S®

Diagnostic & Treatment Center
Kirby Glen



DT0087

Department of Radiology

MRI

Safety Form

PRE-SCAN METAL SCREENING

Last Name:	First:	M.I.	Height:
Today's Date:	Date of Birth:	Weight:	

FOR INPATIENTS ONLY

This section to be completed by nurse:

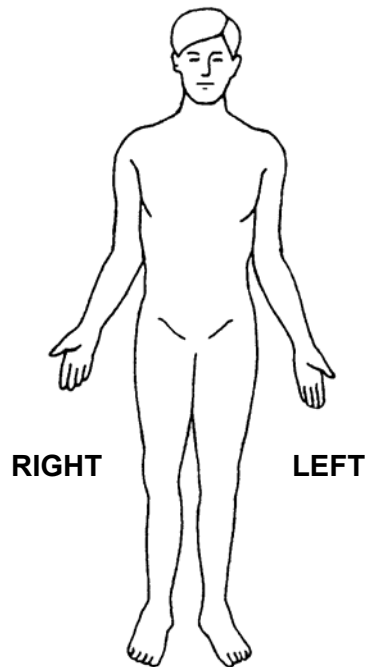
Page 1 of 2

1. Has the patient had an invasive procedure since filling out this form?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Does the patient have a pacemaker / ICD?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3. Does the patient have a sandbag?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4. Does the patient have a temperature probe?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Does the patient have a Swanz Ganz catheter or IABP?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
6. Does the patient have an intracranial aneurysm clip?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cardiac pacemaker
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Implanted cardiac defibrillator
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Internal pacing wires
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aneurysm clip/s - Intracranial
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Carotid artery vascular clamp
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurostimulator
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Implanted drug infusion pump
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bone growth/fusion stimulator
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cochlear, otologic, or ear implant
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any type of prosthesis (eye, penile, etc.)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Valve prosthesis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Artificial limb or joint
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Electrodes (on body, head or brain)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Intravascular stents, filters, or coils
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shunt (spinal or intraventricular)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vascular access port and/or catheter
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Transdermal delivery system (Nitro)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	IUD or diaphragm
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tattooed makeup (eyeliner, lips, etc.)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Body piercing(s)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any metal fragments (eyes, body, etc.)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Metal or wire mesh implants
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Wire sutures or surgical staples
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Harrington rods (spine)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Metal rods in bones
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint replacement _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bone/joint pin, screw, nail, wire, plate
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing aid (REMOVE BEFORE MRI)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dentures (REMOVE BEFORE MRI)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Motion disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Claustrophobia
Other, please explain: _____		

Please mark on the figure below, the location of any implant or metal inside of or on your body.



Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, watch, safety pins, paper-clips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife & clothing with metal in the material.

NOTE: Patients are required to wear earplugs or ear-phones during the MRI examination.

- 1. Have you ever had surgery or an invasive procedure? If yes, please list: No Yes
 Type: _____ Date: _____
 Type: _____ Date: _____
- 2. Have you had any previous MRI studies? If yes, please identify: No Yes
 BODY PART DATE FACILITY / LOCATION

- 3. Do you have drug allergies? If yes, list: _____ No Yes
- 4. Have you ever had asthma, allergic reaction, respiratory disease, or other reaction to a contrast medium or dye used for a MRI? If yes, please describe: No Yes

FEMALE PATIENTS

- 5. Are you pregnant or experiencing a late menstrual period? No Yes
- 6. Date of last menstrual period: _____ Are you breast feeding? No Yes
- 7. Are you taking any type of fertility medication or having fertility treatments? No Yes

For Patients Having an MRI of the Heart or Vascular System:

St. Luke's Episcopal Hospital is an internationally recognized center for cardiovascular care and Cardiovascular Magnetic Resonance Imaging (CVMRI) research. CVMRI is an ever-changing field that requires constant development and testing of new MRI imaging techniques (all of which conform to FDA regulations). During your examination we may request to do extra imaging (no longer than an additional 5 minutes) for quality control, quality assurance, or research purposes. If you agree to participate, the imaging data collected may be used in research publications or presentations, but no data or images identifying you will be used. Your participation is voluntary and you may decline to have the additional imaging without decreasing the quality of the regular MRI scan your doctor has ordered.

- ____ Yes, I agree that additional images may be taken during my MRI examination.
- ____ No, I do not want additional images taken during my MRI examination.

_____ **Patient Signature** _____ **Date** _____ **Witness Signature**

Form Completed by: Patient Relative Physician Other

Signature of Person Completing Form

Name & Relationship to Patient

I have discussed with the patient the importance of not moving during the exam, the loud noises involved with the exam, and the possibility of body temperature rise during the examination. I have instructed the patient to use the call button if he/she needs anything at any time during the examination. **Technologist Initials** _____

STAFF SIGNATURES:



MRI Technologist

MRI Coordinator

Nurse

Radiologist [Metal Approval]

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To contact MRI call
56250 or 832-355-6250