Safety Screening form for Magnetic Resonance Imaging Procedures
Naval Hospital Camp Lejeune

Date_____

Patient Name:_____
DOB: _____ **Age:** _____
SSN:_____
Height/Weight: _____ **Sex Select One**
Home Ph: _____ **Work Ph:** _____
Why are you having this examination (medical problem)? _____

Yes (please explain) or **No**

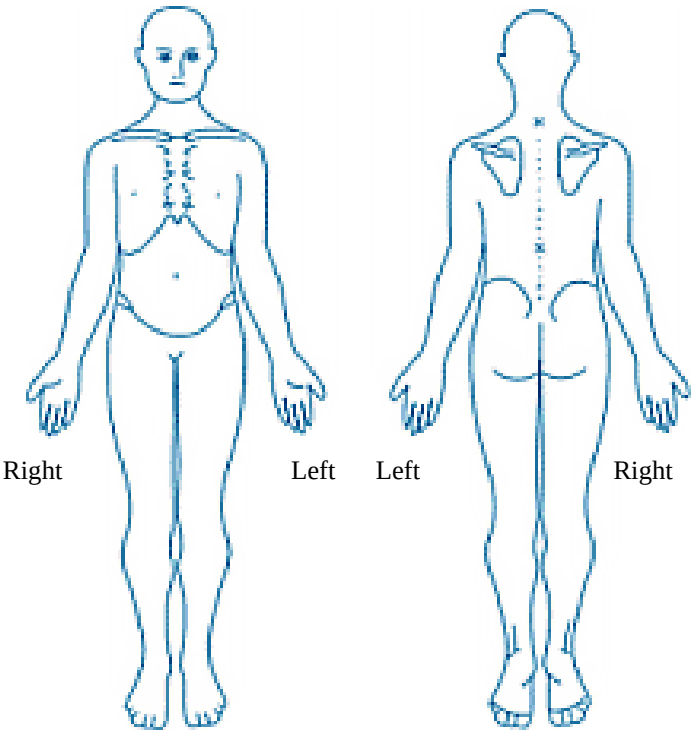
1. Have you ever had an MRI before and had a problem?
   _____
2. Have you ever had a surgical operation or procedure of any kind within the last 6 weeks?
   _____
3. Have you ever been injured by a metal object or foreign body (e.g., bullet, BB, shrapnel)? Where?
   _____
4. Have you ever had an injury from a metal object in your eye (metal slivers, metal shavings, other metal objects)? _____
5. Do you have a history of kidney disease, hypertension, diabetes, asthma and have had recent blood work taken?
   _____
6. If yes, when and where?
   _____
7. Do you have any drug allergies?
   _____
8. Please list medications you are taking._____
9. _____
   _____
   _____
10. Have you ever had an X-ray dye or magnetic resonance imaging (MRI) contrast agent allergic reaction?
    _____
11. Previous MRI if yes location
    _____
12. Previous CT if yes location
    _____
13. Previous X-rays if yes location
    _____

Female Patients:

14. Are you pregnant or suspect that you may be pregnant?
    _____
15. Are you breast feeding?
    _____
16. Date of last menstrual period _____

MRI Hazard Checklist

Please mark on the drawing indicating the location of any metal (M), prior surgery (S) and or site of pain (P).



The following items may be harmful to you during your MRI scan or may interfere with the MRI examination. You must provide a "yes" or "no" for every item. Please indicate if you have or have had any of the following:

YES NO

____ ____ Any type of electronic, mechanical, or metal implants.
Type: _____
____ ____ Cardiac Pacemaker
____ ____ Aneurysm clip
____ ____ Implantable cardiac defrillator
____ ____ Neurostimulator
____ ____ Heart valve
Type: _____
____ ____ Any type of internal electrodes or wires
____ ____ Cochlear implant
____ ____ Hearing Aid
____ ____ Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)
____ ____ Bullets, BB's or Metal Fragments
____ ____Any type of coil, filter, or stent
Type: _____

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YES NO

____ ____ Any type of metal object (e.g., shrapnel, bullet, BB)
____ ____ Artificial heart valve
____ ____ Any type of ear implant
____ ____ Penile implant
____ ____ Artificial eye
____ ____ Eyelid spring
____ ____ Wig, hair implants
____ ____ Tattoos or tattooed eyeliner
____ ____ Radiation Seeds (e.g., cancer treatment)
____ ____ Tissue Expander (e.g., breast)
____ ____ Shunt
____ ____ Jewelry
____ ____ Diaphragm, IUD, pessary
Type: _____
____ ____ Body Piercing
Location: _____
____ ____ History of Cancer or Tumor
Where: _____

____ ____ Diabetes or Asthma
____ ____ Removable dentures, false teeth, or partial plate
____ ____ Surgical mesh
Location: _____
____ ____ Artificial limb or joint
What and where: _____
____ ____ Any other type of implanted item
Type: _____

Medication currently taken:

_____
_____
_____
_____

Instructions for the Patient

1. You are required to use the ear plugs that we supply for use during your MRI because the noise levels may affect your hearing.
2. Remove all jewelry (necklace, pins, rings)
3. Remove all hair pins, bobby pins, barrettes, clips, etc.
4. Remove all dentures, false teeth, partial dental plates.
5. Remove hearing aids
6. Remove eye glasses
7. Remove your watch, pager, cell phone, credit and bank cards, and all other cards with a magnetic strip.
8. Remove all body piercing objects
9. Use gown, if provided, or remove all clothing with metal fasteners, zippers, etc

I attest that 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 of this form.

Patient signature_____

RT Signature: _____

Printed name of RT: _____
Date: _____

Hazard Checklist for MRI Personnel

Your doctor may deem it necessary to give you an IV injection of a contrast liquid containing gadolinium.

Patient Name: _____
Patient SSN: _____
Referring Physician_____

YES NO

____ ____ Have you had an allergic reaction to contrast

Have you had recent bloodwork
____ ____ Renal failure or Dialysis
Any type of hypertension, renal disease

Contrast Procedure:
_____
Technologist:_____

Creat or Gfr _____
Contrast Material & Dosage_____
Site_____

Lot #_____
Expiration date_____

Patients weight_____
Patients signature_____