UCLA Health System
Radiology

[PATIENT ID LABEL]

SAFETY SCREENING FORM FOR MAGNETIC RESONANCE (MR) PROCEDURES

Sex:_______ Age:_______Height:________Weight:_______

1. Have you ever had an MRI examination before and had a problem?
If YES, please describe:____

2. Have you ever been injured by a metallic foreign object? (e.g.; bullet, shrapnel) ___Y___N
If YES, where? ____________ Has the object been removed? ___Y___N

3. Have you ever had an injury from a metal object in your eye (metal slivers, metal shavings, other metal object)? If YES, did you seek medical attention? ____Y____N
If YES, describe what was found____

4. Have you had surgery? _____Y ____N Radiation Treatments? ______Y___ _N

5. Do you have a history of kidney disease? _____Y___N
If YES, are you on hemodialysis?______Y_____N Peritoneal dialysis? ____Y ____ N

6. Do you have a history of high blood pressure? ____Y____N

7. Are you a diabetic? ____Y____N

8. Do you use non-steroidal anti-inflammatory drugs on a daily basis? ____Y_____N

9. Do you have a history of congestive heart failure? ______Y____N

10. Do you have a history of liver disease? ______Y____N

11. Do you have cancer or a history of cancer? ______Y____N

12. Do you have any drug allergies? ____Y___N Latex allergy? ______Y______N
If YES, please list the drugs____
If YES, please describe the reaction______________________________________

13. Are you pregnant or suspect you are pregnant? ______Y ____N
Are you breast feeding? ______Y____N

13. Date of last menstrual period___________Post-menopausal?_______Y____N

14. Have you ever received a X-ray dye or contrast agent used for MRI, CT, or other X-ray or study? _____Y____N

15. Have you ever had an X-ray dye or MRI contrast agent allergic reaction?_____Y___N
If YES, please describe____

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SAFETY SCREENING FORM FOR MAGNETIC RESONANCE (MR) PROCEDURES (pg. 2)

MR Hazard Checklist

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

YES NO

______ _____Any type of electronic, mechanical, or magnetic implant
Type____
______ _____Cardiac pacemaker
______ _____Aneurysm clip(s)
______ _____Implanted cardiac defibrillator/ICD
______ _____Neurostimulator
______ _____Biostimulator
Type ____
______ _____Any type of internal electrodes or wires (e.g., pacing wires, VNS wires)
Type ____
______ _____Cochlear implant
______ _____Hearing aid
______ _____Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)
______ _____Halo vest
______ _____Spinal fixation device or spinal fusion procedure
______ _____Any type of coil, filter or stent (e.g., Gianturco coil, IVC filter, etc.)
Type ____
______ _____Any type of metal object (e.g., shrapnel, bullet, BB)
______ _____Artificial heart valve
______ _____Any type of ear implant
______ _____Artificial eye
______ _____Eyelid spring
______ _____Penile implant
______ _____Any type of implant held in place by a magnet
Type___________________________________
______ _____Any type of surgical clip or staple
______ _____Any implanted items (e.g., pins, rods, screws, nails, plates, wires)
______ _____Artificial limb or joint… What and where_______________________
______ _____Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, PICC line)
Type___________________________________
______ _____Medication patch (e.g., nitroglycerine, nicotine, estrogen)
______ _____Shunt
______ _____Tissue expander (e.g., breast)
______ _____Removable dentures, false teeth, partial plate, retainers, braces
______ _____Diaphragm, IUD, pessary…Type ________________________________
______ _____Surgical mesh………………Location________________________________
______ _____Body piercing……………… Location________________________________
______ _____Wig, hair implants
______ _____Tattoos or tattooed eyeliner or eyebrows
______ _____Radiation seeds (e.g., cancer treatment)
______ _____Any other type or implanted item….Type____________________________

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SAFETY SCREENING FORM FOR MAGNETIC RESONANCE (MR) PROCEDURES (pg. 3)

Instructions for the Patient, Parent, Guardian

1. You are urged to use the ear plugs or the headphones that we supply for use during the MRI examination since some patients may find the noise levels unacceptable, and the noise levels may affect your hearing.
2. Remove all jewelry (e.g., necklaces, bracelets, earrings, rings).
3. Remove all body piercing objects.
4. Remove all hair pins, bobby pins, barrettes, clips, etc.
5. Remove all dentures, false teeth, partial dental plates, retainers.
6. Remove hearing aids.
7. Remove eyeglasses.
8. Remove your watch, wallet, pager, cell phone, keys, nail clippers, money clips, cigarette lighters, and all credit and bank cards with a magnetic strip
9. Use the gown and bottoms, if provided and remove all clothing with metal fasteners, snaps and zippers. Remove your belt and shoes.
10. Lock your clothes and valuables in the locker provided. Remove the key and take it with you.
11. Please use the restroom before your MRI examination.

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

______________________________ ____________________
MR Tech/RN/MD Signature Date

____
Print name of MR Tech, RN, MD

FOR MRI STAFF USE ONLY

CONTRAST ORDER/SIGNATURE	**To Be Filed in the Medical Record**
Contrast Type:____________ **Injection Rate:**______ **Injection Amount:** ______ **MR Tech/RN Signature**____________________________	
Creatinine: ______ **GFR:** ________ **MR Tech Signature:** __________________ **Creatinine screening waived by:**____________________________	
Radiologist Signature: ____________________________ **Date:** _________	