MRI Screening Sheet

Patient Name: _____

Date:_____ Date of Birth_____

Please indicate if you have any of the following:	**Yes**	**No**	**Approx. Date Put in**
Transdermal drug patch	☐	☐	_____
Cardiac Pacemakers	☐	☐	_____
Coronary stents	☐	☐	_____
Brain Aneurysm clips	☐	☐	_____
Aortic clips	☐	☐	_____
Implanted neurotransmitter (i.e. bone stimulator, T.I.N.S unit)	☐	☐	_____
Insulin pump	☐	☐	_____
Hearing aids	☐	☐	_____
Joint Replacement	☐	☐	_____
Fractured bones treated w/metal rods plates, screws, nails, or clips	☐	☐	_____
Prosthesis	☐	☐	_____
Metal slivers in eyes (from welding, grinding, eye injury, etc.)	☐	☐	_____
Cochlear implants	☐	☐	_____
Shrapnel	☐	☐	_____
Pregnancy	☐	☐	_____
Have you ever had an MRI before?	☐	☐	_____

If so, where and when_____

Other: _____

NOTE:

Ensure that the following items are removed before scanning:

- Cell phone, purse, wallet, or money clip ☐
- Jewelry (for wrist and hand exams) ☐
- Watch, keys, or pocket knife ☐
- Credit cards and bank cards with magnetic strips ☐

List all major surgeries: _____

_____

Patient Signature _____ Date _____

MRI Technologist Signature _____ Date _____