Wake Forest®
Baptist Health

Place Pt Barcode Label Here

Name:

Date of Birth:

Magnetic Resonance Imaging (MRI) questionnaire

Reason for MRI and/or Symptoms _____

_____

_____

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MRI procedure. Do not enter the MRI scanner room or MRI environment if you have any question or concern regarding an implant, device, or object. Consult the MRI technologist BEFORE entering the MRI room. The MRI Magnet is ALWAYS on.

1. **Patient Height** _____ **Patient Weight** _____
2. Do you have a **cardiac pacemaker** or **implanted cardiac defibrillator (ICD)**? ☐ YES ☐ NO
3. Do you have a **cerebral aneurysm clip** (a clip on a blood vessel) in your brain? ☐ YES ☐ NO
4. Have you ever worked with, or been hit in the eye with a **piece of metal**? ☐ YES ☐ NO
   If **YES**, was it removed by a physician? ☐ YES ☐ NO If **NO**, Is there a chance it is still there? ☐ YES ☐ NO
5. Are you **pregnant, possibly pregnant**? ☐ YES ☐ NO First day of LMP: _____
6. **Please list any prior surgery that you have had with the approximate dates:**

   _____

   _____

   _____
7. Do you have a **shunt**? ☐ YES ☐ NO If **YES**, is it programmable? ☐ YES ☐ NO
8. Do you have any metal objects implanted inside your body? ☐ YES ☐ NO If **YES**, please tell us **what the object is** and **where it is located** in your body. _____

   _____
9. Do you have any of the following items in/on your body?

YES	NO		YES	NO	
☐	☐	Electronic implant or device	☐	☐	Port a Cath
☐	☐	Magnetically-activated implant or device	☐	☐	Radiation seeds or implants
☐	☐	Neurostimulation system	☐	☐	Medication patch (Nicotine, Nitroglycerine)
☐	☐	Spinal cord stimulator	☐	☐	Any metallic fragment or foreign body
☐	☐	Internal electrodes or wires	☐	☐	Tissue expander
☐	☐	Bone growth/bone fusion stimulator	☐	☐	Surgical Staples
☐	☐	Cochlear, otologic or other ear implant	☐	☐	Joint replacement
☐	☐	Insulin or other infusion pump	☐	☐	Bone/joint pin, screw, nail, wire, plate, etc.
☐	☐	Glucose monitor	☐	☐	IUD
☐	☐	Implanted drug infusion device	☐	☐	Dentures, or partial plates
☐	☐	Any type of prosthesis (eye, penile, etc.)	☐	☐	Tattoo or permanent makeup
☐	☐	Heart valve prosthesis	☐	☐	Body piercing jewelry
☐	☐	Eyelid spring or wire	☐	☐	Hearing aid
☐	☐	Artificial or prosthetic limb	☐	☐	Other implant: _____
☐	☐	Vascular Stent, filter or coil	☐	☐	Breathing problem or motion disorder

For your safety: Before entering the MR environment, you must remove all metallic objects such as **jewelry, piercings, hearing aids, dentures or partial plates and artificial limbs/prostheses.** You will **be required to change into clothing provided by the facility** prior to scanning. Please consult the MRI Technologist if you have any questions **BEFORE** you enter the MR System Room. Please be advised that you will be **required to wear earplugs** during the MRI procedure.

(Continue to other side)

ASESRA

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10. Do you have any of the following diseases?

YES	NO	
☐	☐	Diabetes
☐	☐	Hypertension (High Blood Pressure) If **YES**, do you take medication? _____
☐	☐	Kidney Disease If **YES**, are you on dialysis? _____
☐	☐	Cancer If **YES**, what part of the body? _____
		When was it diagnosed? _____

11. As part of your examination, the MRI radiologist may deem it advisable to give you an I.V. injection of **gadolinium** contrast to more accurately diagnose your condition.

Have you ever had a previous allergic reaction to MRI **gadolinium** contrast? ☐ **YES** ☐ **NO**

If **YES**, indicate type of reaction: _____
If **YES**, did you take a 13 hour pre-medication for this exam? ☐ YES ☐ NO

I attest that the answers I have provided to the questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding any information on this form.

Signature (Patient or Guardian): X _____ Date: _____ Time: _____

Patient has been MRI safety screened by at least ONE Level II MRI Personnel and all external contraindicated devices have been removed.

By: _____ Date: _____ Time: _____

Level 2 Signature _____ Date: _____ Time: _____

FOR MRI STAFF ONLY

All inpatients will be cleared for any possible contraindicated/interfering devices including:

☐ YES ☐ NO Foley temperature probe	Is it a BARD temperature probe? ☐ YES ☐ NO (if no, must be removed)
☐ YES ☐ NO Rectal temperature probe	If YES, was it removed? ☐ YES ☐ NO
☐ YES ☐ NO Metal endo-tracheal tube	If YES, was it removed? ☐ YES ☐ NO
☐ YES ☐ NO Endo-tracheal tube with coil/spring	If YES, was it removed? ☐ YES ☐ NO
☐ YES ☐ NO Swan-Ganz catheter	If YES, was it removed? ☐ YES ☐ NO
☐ YES ☐ NO Ferrous external fixation device	If YES, was it removed? ☐ YES ☐ NO
☐ YES ☐ NO Electrodes	If YES, are they MR Conditional? ☐ YES ☐ NO (if no, must be removed)
☐ YES ☐ NO Medication patches	If YES, was it removed? ☐ YES ☐ NO
☐ YES ☐ NO Pulse oximeter	If YES, was it removed? ☐ YES ☐ NO

MRI Staff Signature: _____ **Date:** _____ **Time:** _____

*When verification of MRI compatibility must be made of any questionable interfering device/object **by a radiologist**, their signature is required:*

Device/object in question: _____

Radiologist Signature: _____ **Date:** _____ **Time:** _____