### MRI Safety Checklist

1. Have you had an MRI? .................................................................No ___ Yes ___
   Did you have any difficulty related to the procedure? ..............................No ___ Yes ___
   If yes, please describe: ________________________________________________

2. Do you have or have you had a pacemaker, ICD or defibrillator? ..................No ___ Yes ___

3. Have you ever worked with grinding metals or had metal fragments in your eyes? No ___ Yes ___

4. Have you ever had a reaction or ill effect from MRI contrast material (gadolinium)? No ___ Yes ___
   If yes, please describe: ________________________________________________

5. Do you have medicine or food allergies? ...............................................No ___ Yes ___
   If yes, please describe: ________________________________________________

6. Do you have sickle cell disease? .........................................................No ___ Yes ___
   If yes, are you in sickle cell crisis? .......................................................No ___ Yes ___

7. Do you have kidney (renal) problems or a kidney transplant? .........................No ___ Yes ___

8. Have you been told your kidneys are not working properly? .........................No ___ Yes ___

9. Are you on kidney dialysis? .............................................................No ___ Yes ___

10. Do you have diabetes (high blood sugar)? ............................................No ___ Yes ___

11. Female Patients Only: Is there a possibility that you might be pregnant? ........No ___ Yes ___
   Are you currently breastfeeding? .........................................................No ___ Yes ___

### WARNING:
Certain implants, devices, or objects may be hazardous to you and/or interfere with MRI studies. Do not enter the MRI area if you have any questions regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MRI room.

The MRI magnet is ALWAYS on.

<table>
<thead>
<tr>
<th>Do you have or have you had? (Circle No or Yes)</th>
<th>Describe:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aneurysm clips, coil or graft........................</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Vascular stent, coil, clips or clamps .............</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Cardiovascular catheter / Swan-Ganz catheter ....</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Heart valve replacement ................................</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Implanted filter (i.e. Inferior Vena Cava filter)</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Brain surgery clips ........................................</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Implanted stimulator (i.e. vagal nerve, deep brain, TENS, bone growth)</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Implanted infusion pump, catheter or device ......</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Programmable shunt or VP shunt ......................</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Magnetically-activated implant or device ..........</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Internal or external monitoring devices (incl. temp or oxygen probes)</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Epidural or nerve block catheter ....................</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Stapes prosthesis, cochlear implant ................</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Eye prosthesis, lens implant, eyelid spring or wire, retinal tack</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Internal electrodes or wires ........................</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Medication patch (nitroglycerine, nicotine, hormones, other medication)</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Antimicrobial wound or burn dressing ................</td>
<td>No / Yes</td>
</tr>
<tr>
<td>Ingested camera pill for capsule endoscopy .......</td>
<td>No / Yes</td>
</tr>
</tbody>
</table>

Please continue on next page
MRI Safety Checklist

Do you have or have you had? (Circle No or Yes)

Dental implant, dentures or partial plates……………………………………… No / Yes
Intrauterine Device (IUD)………………………………………………………... No / Yes
Penile implant…………………………………………………………………….. No / Yes
Bullet or metallic fragments…………………………………………………... No / Yes
Tissue expander (i.e. breast expander)…………………………………………... No / Yes
Permanent make-up, tattoo, piercing…………………………………………... No / Yes
Hearing aid (remove before entering the MRI room)…………………………... No / Yes
Artificial or prosthetic limb……………………………………………………… No / Yes
Joint replacement or resurfacing ……………………………………………….. No / Yes
Any other type of device, implant or prosthesis not listed above: __________________________

List all operations you have had: ________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Weight: ___________ Height: ___________

I have answered these questions to the best of my ability and I understand that possible injury could result if I withhold vital information.

Signature: ___________________________ Relationship to patient: __________________________
(Patient, guardian, or designee)

Inpatients Only: Nurse or MD responsible for reviewing form’s completeness and accuracy:

Printed Name (RN, MD) ___________________________ Signature (RN, MD) ___________________________
Date: ________ Time: ________

Radiology verification of form accuracy and patient safety review:

Printed Name (Technologist/Radiologist) ___________________________ Signature (Technologist/Radiologist) ___________________________
Date: ________ Time: ________

For staff use only below this line

If renal problems, diabetes, or age >65, blood work should be within 30 days for IV contrast.

eGFR (estimated Glomerular Filtration Rate ) _______________ Creatinine _______________

Date of result: _______________ Source: ____ POCT ____ Lab

If GFR < 60 or yes to renal problems / transplant / dialysis and contrast is required, was the information sheet regarding gadolinium given to the patient? Yes / No

Gadolinium given: Yes ___ No ___ CONTRAST: ___________________________ VOLUME: ________ mL

If no, explain: ________________________________________________________________

Approving Radiologist if eGFR < 30: ____________________________________________

TECHNOLOGIST: ____________________________________________________________

Printed Name ________ Signature ________ Date ________ Time ________

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Department of Radiology