MRI SAFETY INFORMATION SHEET

Print Name: _____

Patient Name: Date of Birth:

Do you have or have you had any of the following:					
Aneurysm clips	❑ Yes ❑ No	Hearing Aids	❑ Yes ❑ No	Metal fragments in eye, head, skin	❑ Yes ❑ No
Neurostimulator	❑ Yes ❑ No	Heart Valve implant	❑ Yes ❑ No	Joint replacement, pins, plate	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Implanted Pump	❑ Yes ❑ No	Wearing Medication Patch	❑ Yes ❑ No
Pacemaker/ICD	❑ Yes ❑ No	Any body piercings	❑ Yes ❑ No	Injury from Shrapnel/BBs	❑ Yes ❑ No
Ear/Eye implant	❑ Yes ❑ No	Any type prosthesis	❑ Yes ❑ No	Dentures, partial plate or braces	❑ Yes ❑ No
Metal Worker/ Welder	❑ Yes ❑ No			Venous Access/Port Device	❑ Yes ❑ No

Surgical History:	
List **ALL** surgeries you have ever had in your life:	
Have you hemidiaphragm ANY surgery in the last 8 weeks?	❑ Yes ❑ No If yes, what type:

Females Only:			
Are you pregnant:	❑ Yes ❑ No	Are you breastfeeding:	❑ Yes ❑ No
Last Menstrual Period:			

Signature: _____ Date: _____

MR Technologist Signature: _____