THE University of Vermont MEDICAL CENTER

Patient name:_____

MRI Safety Questionnaire

1.Please indicate if you have any of the following:

☐ YES ☐ NO HAVE YOU EVER HAD A PIECE OF METAL GET INTO YOUR EYE, IF SO WHEN?:_____

☐ YES ☐ NO INJURY WITH METALLIC FRAGMENTS OR FOREIGN BODY

☐ YES ☐ NO EYELID SPRING OR WIRE

☐ YES ☐ NO ANEURYSM CLIP(S) OR ANEURYSM COILING

☐ YES ☐ NO CARDIAC PACEMAKER, DEFIBRILLATOR, HEART VALVE PROSTHESIS, IF SO WHEN?:_____

☐ YES ☐ NO ELECTRONIC IMPLANT OR DEVICE (I.E. PUMP OR STIMULATOR)

☐ YES ☐ NO INTERNAL ELECTRODES OR WIRES

☐ YES ☐ NO COCHLEAR, OTOLOGIC, HEARING AID(S) OR OTHER EAR IMPLANT

☐ YES ☐ NO OTHER IMPLANTS?:_____

☐ YES ☐ NO ANY TYPE OF PROSTHESIS (I.E. EYE, PENILE, LEG, ETC.) OTHER:_____

☐ YES ☐ NO METALLIC STENT, COIL OR IVC FILTER

☐ YES ☐ NO SHUNT (I.E. SPINAL OR INTRAVENTRICULAR)

☐ YES ☐ NO VASCULAR ACCESS PORT AND/OR CATHETER

☐ YES ☐ NO TISSUE EXPANDER (I.E. BREAST)

☐ YES ☐ NO ORTHOPEDIC HARDWARE (I.E. JOINT REPLACEMENT, PIN, WIRE, ETC.), IF SO WHERE?:_____

☐ YES ☐ NO MEDICATION PATCH ON SKIN

☐ YES ☐ NO TATTOO OR PERMANENT MAKEUP

☐ YES ☐ NO BODY PIERCING JEWELRY

☐ YES ☐ NO DO YOU HAVE A HISTORY OF KIDNEY DISEASE

☐ YES ☐ NO DO YOU HAVE A HISTORY OF HIGH BLOOD PRESSURE

☐ YES ☐ NO DO YOU HAVE A HISTORY OF DIABETES

☐ YES ☐ NO DO YOU HAVE A HISTORY OF LIVER DISEASE

☐ YES ☐ NO BREATHING PROBLEMS OR MOTION DISORDER

☐ YES ☐ NO CLAUSTROPHOBIA? MEDS?: Yes or No

Office Use Only

Creatinine_____GFR_____Date_____

(If over 15mg/dl send pt to lab stat)

Normal range: >18 years 0.6-1.3 mg/dl

2. Please provide your approximate weight:_____

3. Is there a chance that you are pregnant? ☐ YES ☐ NO ***DATE OF LMP?:_____***

4. IUD, Diaphragm, or Pessary? ☐ YES ☐ NO

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of person completing form:_____Date: ____/____/____

Form completed by?(Please circle) Patient / Relative / Nurse _____ _____

PRINT NAME RELATION TO PATIENT

Office use only in shaded area

Form reviewed by: _____ _____

INITIALS SIGNATURE

MRI Technologist ____ MA ____ RN ____ Radiologist ____ Other(Please state) _____