Nemours® Children's Hospital

Patient Name: _____

MRN: _____

Date of Service: _____

Safety Screening for Magnetic Resonance Imaging

Form# 82010

WARNING: MRI is a simple and painless examination. However, because you will be in a strong magnet environment, metal objects in or on your body may be hazardous to yourself or others in the scan room with you. Answering the following questions will provide us with important information BEFORE entering the MRI scan room. The magnet is always on!

Please answer the following questions:

1. Has the patient had any prior surgery, an operation or an invasive procedure of any kind? ❑Yes ❑No
   If yes, please indicate the date and type of surgery:

   Date_____/_____/_____ Type of surgery _____

   Date_____/_____/_____ Type of surgery _____

   Date_____/_____/_____ Type of surgery _____

2. Has the patient had any GI procedure (e.g., endoscopy/colonoscopy) within the last 9 months? ❑Yes ❑No
   If yes, please indicate the date:_____/_____/_____ What facility? _____

3. Has the patient had any prior diagnostic imaging study on the part of the body we're scanning today? ❑Yes ❑No
   If yes, please list:_____

4. Has the patient experienced any problem related to a previous MRI examination or MRI procedure? ❑Yes ❑No
   If yes, please describe:_____

5. Has the patient ever worked with metal or had an injury to the eye involving a metallic object or fragment? (e.g., metallic slivers shavings, foreign body, etc.) to the eye or other part of the body? ❑Yes ❑No
   If yes, please describe:_____

6. Has the patient ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ❑Yes ❑No
   If yes, please describe:_____

WARNING: Sometimes an MRI requires an injection of contrast called gadolinium. It is administered through a small needle which is inserted into a vein in your arm. You may experience the sensation of the contrast being injected, which is normal and expected.

7. Is the patient currently taking or has recently taken any medication or drug? ❑Yes ❑No
   If yes, please describe:_____

8. Is the patient allergic to any medications? ❑Yes ❑No
   If yes, please list:_____

9. Does the patient have a history of asthma, allergic reactions, respiratory disease or reaction to a contrast media or dye used for an MRI, CT or X-ray examination? ❑Yes ❑No
   If yes, please describe:_____

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10. Does the patient have anemia or any disease(s) that effects your blood, a history of kidney disease, kidney failure, kidney transplant, high blood pressure (hypertension), liver disease or seizures? ❑Yes ❑No

If yes, please describe:_____

11. Does the patient have a personal history of Cancer? ❑Yes ❑No

12. Date of last menstrual period:_____

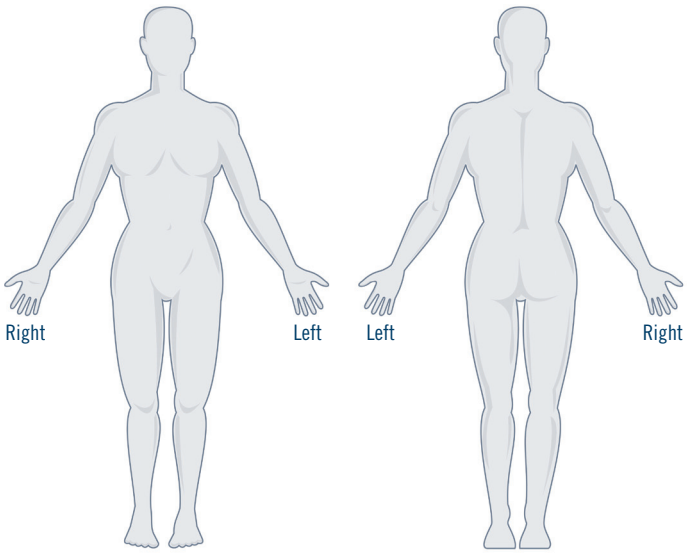
13. Is the patient pregnant or is there a possibility that she may be pregnant? ❑Yes ❑No

NOTE: You are required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

Please indicate if you have any of the following:

Cardiac pacemaker	❑Yes	❑No	Dentures or partial plates	❑Yes	❑No
Tracking anklet/device	❑Yes	❑No	Tattoo or permanent eye makeup	❑Yes	❑No
Implanted cardioverter defibrillator (ICD)	❑Yes	❑No	Body piercing jewelry	❑Yes	❑No
Cochlear, otologic or other ear implants	❑Yes	❑No	Hearing Aid (remove before entering)	❑Yes	❑No
Aneurysm clips	❑Yes	❑No	Other implant _____	❑Yes	❑No
Electronic implant or device	❑Yes	❑No	Breathing problem or motion disorder	❑Yes	❑No
Magnetically-activated implant or device	❑Yes	❑No	Claustrophobia	❑Yes	❑No
Neurostimulation system	❑Yes	❑No	Hospital tracking device	❑Yes	❑No
Spinal cord stimulator	❑Yes	❑No			
Internal electrodes/wires	❑Yes	❑No			
Insulin or other infusion pump	❑Yes	❑No			
Implanted drug infusion pump	❑Yes	❑No			
Any type of prosthesis (eye, penile, etc.)	❑Yes	❑No			
Heart valve prosthesis	❑Yes	❑No			
Eyelid spring or wire	❑Yes	❑No			
Artificial or prosthetic limb	❑Yes	❑No			
Metallic stent, filter or coil	❑Yes	❑No			
Shunt (spinal or intraventricular)	❑Yes	❑No			
Vascular access port or catheter	❑Yes	❑No			
Radiation seeds or implants	❑Yes	❑No			
Swan-Ganz or thermo dilution catheter	❑Yes	❑No			
Medication patch (Nicotine, Nitroglyc)	❑Yes	❑No			
Any metallic foreign body or fragment	❑Yes	❑No			
Tissue expander (e.g., breast)	❑Yes	❑No			
Surgical staple, clips or metallic sutures	❑Yes	❑No			
Joint replacement (hip, knee, etc.)	❑Yes	❑No			
Bone/joint pin, screw, nail, wire, plate,	❑Yes	❑No			
IUD (intrauterine device), diaphragm pessary	❑Yes	❑No			

Please indicate on the figure below the location of any implant or metal inside or on your body.



Signature of Person Completing Form:_____ Date_____/_____/_____

Relationship to Patient:_____

Technologist Reviewing the Form with Parent/Guardian:_____ Date_____/_____/_____

Technologist's Signature:_____