Magnetic Resonance Imaging (MRI) - Patient Screening

TO BE SCANNED

Form content retained in medical record.
Route to scanning.

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*	
Birth Date *(mm-dd-yyyy)*	Room Number (if applicable)
Mayo Clinic Number	

Weight *(lb.)*	Height *(ft. in.)*	If someone else is filling out this form for the patient, please print your name below.	Date *(mm-dd-yyyy)*

For your safety and to prevent possible injury:

- Is it possible you are pregnant? ☐ Yes ☐ No
- Do you have medication patches on? ☐ Yes ☐ No

Do you now or have you EVER had:

- Pacemaker or defibrillator (ICD)? ☐ Yes ☐ No
- Deep brain stimulator (DBS)? ☐ Yes ☐ No
- Vagal nerve stimulator (VNS)? ☐ Yes ☐ No
- Other neuro stimulator? ☐ Yes ☐ No
  *If yes, specify*____________________
- Aneurysm clips in your head? ☐ Yes ☐ No
  *If yes, specify when placed (month/year)*____________________
- Tissue expander? ☐ Yes ☐ No
- Gastrointestinal clips or pill cameras within the last 90 days? ☐ Yes ☐ No
- Esophageal reflux management system (LINX)? ☐ Yes ☐ No
- Cochlear (ear) or auditory implants? ☐ Yes ☐ No
- Any implanted devices with magnets? ☐ Yes ☐ No
- Other implanted electronic devices? ☐ Yes ☐ No
  *If yes, specify*____________________
- Eye injury involving metal? ☐ Yes ☐ No

If you answered Yes to any of these questions, stop and speak to the desk attendant.

RADSCN

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(continued)

(complete fields or place patient label here)

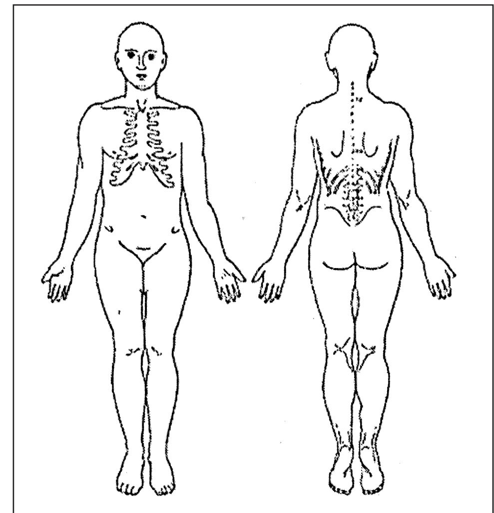
Patient Name *(First, Middle, Last)*
Birth Date *(mm-dd-yyyy)*
Mayo Clinic Number

Do you have any:

The following items might interfere with your scan. Please check either ☒ Yes or ☒ No for each item. *If you check Yes to any item(s), write the name or brand, date (month/year), and if it was performed at a Mayo Clinic facility on the lines below if you know it.*

	Yes	No
Metal rods, plates, pins, screws, wires ______	☐	☐
Insulin pump/drug infusions devices implanted/removable ______	☐	☐
Pellets, bullets, BB's, shrapnel ______	☐	☐
Tattoo eyeliner ______	☐	☐
Ocular (eye) implants ______	☐	☐
Heart valve ______	☐	☐
Artificial limbs ______	☐	☐
TENS unit/bone growth stimulator ______	☐	☐
Diaphragm, intrauterine device, or penile prostheses ______	☐	☐
Implanted catheter, shunt, or tube ______	☐	☐
Back/spine surgery ______	☐	☐
History of cancer ______	☐	☐
Coil, filter, stent, or wire in a blood vessel ______	☐	☐
Any other metal or implanted device, please list: ______	☐	☐

Please mark on this drawing the location of any metal inside your body.



Comments ______________________________

____

Prior to your MRI scan, you will be asked to remove all clothing and change into a gown and robe for your exam. Again, most metallic objects cannot be brought into the scan room. **This includes: Shoes, bra hooks or underwires, hairpins, watches, hearing aids, wigs, hairpieces, back/pelvis support brace, safety pins, earrings, removable dental braces, cell phones, iPod, pocket knife, nail clippers, and any other jewelry. GLASSES AND DENTURES MAY BE REMOVED INSIDE THE SCAN ROOM.**

Office Use Only

FMD Technologist Printed Name	M Number							
☐ Green ☐ Yellow ☐ Red ☐ N/A and Why: ______								
MR Technologist I Printed Name	M Number							
MR Technologist II Printed Name	M Number							

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