CROUSE RADIOLOGY ASSOCIATES METAL SCREENING FORM FOR MRI SCAN

Patient Name: _____ DOB: _____ Exam Date: _____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI scan. Please speak with the MRI Technologist if you have any questions or concerns regarding an implant, device or object.

FOR YOUR SAFETY, IT IS IMPERATIVE TO REMOVE:

- ✔ **HEARING AIDS, BODY PIERCINGS, JEWELRY, WATCHES, WIGS, HAIRPIECES, BOBBY PINS, BARRETTES.**
- ✔ **CLOTHING OR UNDERGARMENTS LABELED WITH ANTI-ODOR, ANTIBACTERIAL, COPPER OR ION-INFUSED, COOLING TECHNOLOGY, REFLECTIVE, OR COLOR-CHANGING TECHNOLOGY.**

Have you had a surgery or procedure in your lifetime? Yes ☐ No ☐

If yes, please list below and give the dates of the surgery or procedure.

1. _____ 3. _____
2. _____ 4. _____

Yes ☐ No ☐ Cardiac pacemaker (permanent or temporary) or defibrillator?
Yes ☐ No ☐ Retained pacemaker wires?
Yes ☐ No ☐ Artificial heart valve or heart prosthesis?
Yes ☐ No ☐ Stent, coil, or filter? What part of the body? _____
Yes ☐ No ☐ Aneurysm clip, coil, or stent?
Yes ☐ No ☐ Neurostimulator or biostimulator? (ex. spinal, bladder, etc.)
Yes ☐ No ☐ Shunt? (spinal or ventricular)
Yes ☐ No ☐ Breast tissue expanders?
Yes ☐ No ☐ Swan Ganz catheter or thermodilution catheter?
Yes ☐ No ☐ Artificial limb or joint? _____
Yes ☐ No ☐ Surgical clips, wires, or mesh? Location? _____
Yes ☐ No ☐ Skin staples?
Yes ☐ No ☐ Cochlear (ear) implants or other ear implants?
Yes ☐ No ☐ Hearing Aid?
Yes ☐ No ☐ Eyelid springs, weights, or wires?
Yes ☐ No ☐ Tattoos, permanent makeup, magnetic eyelashes? Location? _____
Yes ☐ No ☐ Ever had an eye injury with metallic slivers or shavings?
Yes ☐ No ☐ Any artificial prosthesis? (ex. eye, penile, heart, leg, etc.)
Yes ☐ No ☐ Drug infusion device, glucose monitor, or insulin pump?
Yes ☐ No ☐ Any electronic, magnetic, or mechanical implant?
Yes ☐ No ☐ Medication patches? All patches should be removed.
Yes ☐ No ☐ Ever been injured by any metallic object? (ex. bullet, shrapnel, etc.)
Yes ☐ No ☐ Any implanted item not listed? (pins, rods, screws, nails, plates, wires) Location: _____
Yes ☐ No ☐ Are you pregnant or suspect you are pregnant? Consent will be required.

PRE-CONTRAST SCREENING QUESTIONS

Do you have allergies? Yes ☐ No ☐

If yes, please list below the allergy and reaction to allergen.

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Yes ☐ No ☐ Have you ever experienced a severe allergic reaction to anything?
Yes ☐ No ☐ Have you ever had a reaction to contrast given during a CT or MRI scan?
Yes ☐ No ☐ Do you have a history of asthma, allergic respiratory disease, or seizures?
Yes ☐ No ☐ Are you breast feeding?

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Patient Signature: _____ Date & Time: _____ Your Weight: _____

If the patient is incapable of completing this form or is a minor (under 18 years of age), please document the person's name completing this form and their relationship to the patient.

Name: _____ Signature: _____ Relationship to Patient: _____

Reviewing Technologist Signature: _____Date & Time: _____