MRI Safety Screening Form

UOA
University Orthopaedic Associates
A Division of OrthoNJ

Patient Name: _____ Date: _____

Height: _____ Weight: _____

Please indicate if you have any of the following:

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

1) Are you pregnant? ☐ Yes ☐ No ☐ NA

2) When did your symptoms begin? _____

3) Do you have any allergies? ☐ Yes ☐ No

If yes, please indicate: _____

4) History of cancer? ☐ Yes ☐ No

If yes, please indicate: _____

5) Any medical concerns at this time? ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Kidney disease ☐ Yes ☐ No

Smoker ☐ Yes ☐ No

Other (please specify): _____

Signature of person completing this form: _____

Reviewed by Level 1 or 2 Staff: (Print) _____ (Signature) _____

MRI Technologist: (Print) _____ (Signature) _____