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) _____