MRI Procedure Screening Form

The following items may be hazardous or may cause poor image quality.

Please indicate if you have any of the following:
(If you need help answering any question, please ask a staff member.)

Pacemaker or defibrillator ☐ Yes ☐ No
Ear implant ☐ Yes ☐ No
Tissue expander ☐ Yes ☐ No
Nerve or muscle stimulator ☐ Yes ☐ No

PLEASE NOTE: *If you answered yes to any of the questions above, please stop and talk to a staff member immediately.*

Any type of internal or external electrodes or wires ☐ Yes ☐ No
Type ______________________________

Any other type of electronic or magnetic implant ☐ Yes ☐ No
Type ______________________________

Any clip, coil, filter, screw, rod or stent ☐ Yes ☐ No
Type ______________________________

Any pump or drug dispensing device ☐ Yes ☐ No

Prosthesis or artificial replacement body part ☐ Yes ☐ No
(i.e., eye, knee, hip, leg, etc.)

Hearing aid ☐ Yes ☐ No

Dentures ☐ Yes ☐ No

Patch-type medication ☐ Yes ☐ No

Are you wearing a brace? ☐ Yes ☐ No

Any injury involving a metal foreign body? ☐ Yes ☐ No
(i.e., bullet, bb, shrapnel, etc.)

Any eye injury involving metal objects? ☐ Yes ☐ No

Facial tattoos (skin irritation possible during exam) ☐ Yes ☐ No

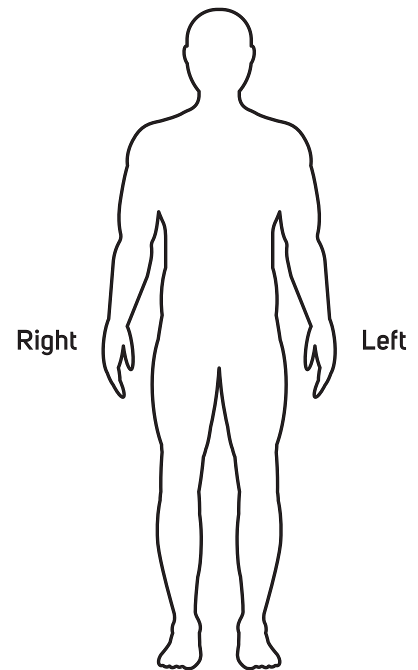
Female patients only:

Are you pregnant or do you suspect pregnancy? ☐ Yes ☐ No

IUD (intrauterine device) ☐ Yes ☐ No

Pessary (internal supporting device) ☐ Yes ☐ No

Please mark this drawing with the location of any objects inside your body.



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

Patient name (Print): ______________________________

Signature: ______________________________

Date: ______________ **Time:** ______________

Staff conducting history review (Print): ______________________________

Signature: ______________________________

Date: ______________ **Time:** ______________

Patient identification