22408-03

Children's Healthcare of Atlanta

MRI SAFETY SCREENING FORM

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Today's date: _____/_____/_____ (MM/DD/YYYY) Your phone number: _____

Age: _____ Sex: ☐ Female ☐ Male **Females Only:** Are you pregnant? ☐ No ☐ Yes

This form is for: ☐ Patient ☐ Parent or guardian ☐ Staff ☐ Other (name): _____

MRI Safety Information:

- The MRI uses a very strong magnet and it is ALWAYS on. Because of this, loose metal objects in and around the MRI can hurt anyone in the area. This includes you and your child. Before you or your child enter the MRI area, remove all metal and electronic objects.
- Please ask about any questions or concerns BEFORE you enter the MRI area. You may talk with the technologist (tech), nurse or radiologist (doctor).
- The MRI makes a very loud noise. You must wear earplugs or other hearing protection during the MRI.

Please answer these questions. Read each question carefully.

1. Have you ever had an MRI? ☐ No ☐ Yes

   If yes:

   When was your MRI?_____

   What was the reason for the MRI?_____

   Were you given medicine to help make you calm, relaxed or sleepy (sedated) for the MRI? ☐ No ☐ Yes

2. Do you have any implanted medical devices? (Talk with the care team if you are not sure.) ☐ No ☐ Yes

   If yes: list the devices

3. Have you ever been hurt by a metal object [like bullet, BB or shrapnel (piece of bomb, shell or object from explosion)]? ☐ No ☐ Yes

   If yes: please share details

4. Have your eyes ever been hurt by a metal object or fragment? ☐ No ☐ Yes

   If yes: please share details

5. Have you ever had any surgery, operation, or heart procedure? ☐ No ☐ Yes

   If yes: please write the date of your most recent surgeries. Include the month, day and year if possible.

   Date _____ type of surgery? _____

   Date _____ type of surgery? _____

   Date _____ type of surgery?

6. Do you have any orthodontic or dental appliances (like dental braces, spacers, palate expanders or a Herbst device)? ☐ No ☐ Yes

   If yes: please share details _____

7. Do you have a Continuous Glucose Monitor (CGM) or Insulin Pump? ☐ No ☐ Yes

   If yes: what kind do you have? _____

8. Do you have a feeding tube? ☐ No ☐ Yes ☐ G-Tube ☐ Mickey Tube ☐ Weight Tube ☐ Other (name) _____

Please check Yes or No for each box below. If you are not sure, you may leave it blank. Please talk with the technologist, nurse or doctor if you have questions.

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☐ No ☐ Yes	Artificial eye, arm, leg or joint
☐ No ☐ Yes	Aortic clip, aneurysm clips, or vascular clamp
☐ No ☐ Yes	Body piercing. **If yes:** where? _____
☐ No ☐ Yes	Heart devices (like artificial valves, or ASD/VSD Amplatzer occluders)
☐ No ☐ Yes	Coils, filter or stent (implanted, or placed in the body)
☐ No ☐ Yes	Dental implants, dentures, partial dentures (partial plate) or teeth that can be removed
☐ No ☐ Yes	Ear or cochlear implant
☐ No ☐ Yes	Electrodes or EKG pads (small, sticky patches with thin wires attached to the skin)
☐ No ☐ Yes	Electrical or mechanical implant (like a penile implant, internal electrodes or wires, or a peripheral nerve catheter)
☐ No ☐ Yes	Electronic implant or device that is turned on (activated) by magnets
☐ No ☐ Yes	Eyelid spring
☐ No ☐ Yes	Hair pins, wig, or barrettes – **you must remove these before you enter the MRI area**
☐ No ☐ Yes	Hearing aid – **you must remove these before you enter the MRI area**
☐ No ☐ Yes	Implanted heart, defibrillator, or pacemaker
☐ No ☐ Yes	Implanted medicine infusion pump (like a baclofen, pain medicine, or chemo pump)
☐ No ☐ Yes	Inserted catheter or port: [like a Tenchoff, Broviac, port-a- cath (port), Swan Ganz, CVL (central line), epidural]
☐ No ☐ Yes	An IUD (intrauterine device) diaphragm or pessary
☐ No ☐ Yes	Magnetic eye lashes, metallic or glitter makeup, or body or hair glitter – **you must remove these before you enter the MRI area**
☐ No ☐ Yes	Metal rod, plates, screws, nails, pins, or wires
☐ No ☐ Yes	Medicine patch (like a nicotine, nitroglycerin, birth control, hormone, pain, or transdermal patch)
☐ No ☐ Yes	Neuro or vagal nerve stimulator. This includes a spinal cord stimulator.
☐ No ☐ Yes	Radiation seeds or implants to help treat cancer
☐ No ☐ Yes	Spinal fixation device that was placed during spinal fusion surgery
☐ No ☐ Yes	Spinal or ventricular shunt (VP) **If yes:** Is it programmable (settings can be changed)? ☐ No ☐ Yes **If programmable:** Have you scheduled a doctor's visit to have it re-programmed? ☐ No ☐ Yes
☐ No ☐ Yes	Surgical staples, clips, or metal sutures
☐ No ☐ Yes	Tattoos or tattooed eyeliner
☐ No ☐ Yes	Tissue expanders such as one to enlarge the breast. **If yes:** what kind and where? _____

I state that the information on this form is correct to the best of my knowledge. I have read and understand the contents of this form. I have had a chance to ask questions about the MRI scan, this form and the information on this form.

Signature (Patient may sign only if at least 18 years old)	**Relationship to patient**	**Date**	**Time**

FOR MRI STAFF ONLY **Patient's Height (cm)** _____ **Patient's Weight (kg)** _____

☐ Patient Identification/Side and Site Correct ☐ Patient Visually Assessed Front and Back

☐ Patient Consents Signed ☐ Patient's Equipment is MRI Safe Equipment

☐ Patient Target Screened/Ferromagnetic Detector Completed ☐ Initial Screening: Interview Conducted by _____

Signature of Time-Out Secondary MRI Personnel (Level 1 or 2) (Only required for clinical exams)	**Date**	**Time**
Signature of Screener (MRI Technologist for clinical exams)	**Date**	**Time**