22408-03

Children's Healthcare of Atlanta
at Town Center - Radiology

MRI SAFETY SCREENING FORM

Name____________________

Date of Birth____________________

MRN#____________________

Account/HAR#____________________

PATIENT IDENTIFICATION

Date: ____________ Phone Number____________

Form for: ☐ Patient ☐ Parent/Guardian ☐ Staff ☐ Other, Name: ____________

Age________ Sex: ☐ Female ☐ Male

Reason for MRI: ____________ **Females Only** - Are you pregnant: ☐ No ☐ Yes

MRI Safety Information:

Because an MRI acts like a giant magnet, loose metallic objects in and around the MRI room can harm anyone in the area, including you and your child. Therefore, before entering the MRI area all metallic and electronic objects must be removed, this includes: hearing aids, keys, beepers, cell phones, hairpins, barrettes, jewelry, body piercing, watch, safety pins, paperclips, money clips, credit cards, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, weapons, and guns.

The MRI system is **ALWAYS** on, so if you have any questions or concerns, please ask the technologist, nurse or radiologist **BEFORE** you enter the MRI room.

The noise that the MRI makes is very loud. In order to prevent possible problems due to the increased noise, earplugs and/or other hearing protection are required during the scan.

Please carefully read and answer the following questions:

1. Have you ever had an MRI? ☐ No ☐ Yes
   If yes, give reason and when ____________
   Were you sedated for the MRI? ☐ No ☐ Yes

2. Do you have any implanted medical devices? ☐ No ☐ Yes
   If yes, list devices ____________

3. Have you ever been injured by a metal object (for example: bullet, BB, shrapnel)? ☐ No ☐ Yes
   If yes, please describe____________

4. Have you ever had an injury to your eyes involving a metal object or fragment? ☐ No ☐ Yes
   If yes, please describe____________

5. Have you ever had any surgery, operation, or heart procedure? ☐ No ☐ Yes
   If yes, please indicate date for the most recent surgeries:
   Date _____/_____/_____ Type of surgery ____________
   Date _____/_____/_____ Type of surgery ____________
   Date _____/_____/_____ Type of surgery ____________

6. Have you had any orthodontic work? ☐ No ☐ Yes
   If yes, please describe ____________

Please check Yes or No for each box below, or leave blank if you do not understand. If you have any questions, please ask the nurse, technologist, or physician.

Name___________________________

Date of Birth___________________________

MRN#___________________________

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PATIENT IDENTIFICATION

☐ No ☐ Yes	Artificial eye, limb, or joint
☐ No ☐ Yes	Aortic clip, aneurysm clips, or vascular clamp
☐ No ☐ Yes	Body piercing. Locations:
☐ No ☐ Yes	Cardiac (heart) devices/surgery, including artificial valves, ASD/VSD, Amplatzer occluder
☐ No ☐ Yes	Coils, filter or stent - implanted
☐ No ☐ Yes	Dental implants, dentures, removable teeth, or partial plate
☐ No ☐ Yes	Ear or cochlear implant
☐ No ☐ Yes	Electrodes or EKG pads
☐ No ☐ Yes	Electrical or mechanical implant such as penile, internal electrodes or wires, peripheral nerve catheter
☐ No ☐ Yes	Electronic implant or device - magnetically - activated
☐ No ☐ Yes	Eyelid spring
☐ No ☐ Yes	Feeding tube, if yes, what type ______________________ ☐ G-Tube ☐ Mickey Tube ☐ Weighted Tube ☐ Other ______________________
☐ No ☐ Yes	Hair pins, wig, or barrettes ***(Remove before entering MRI)***
☐ No ☐ Yes	Hearing aid ***(Remove before entering MRI)***
☐ No ☐ Yes	Implanted heart, defibrillator, or pacemaker
☐ No ☐ Yes	Implanted medicine infusion pump such as baclofen, pain medication, insulin, chemo therapy pump
☐ No ☐ Yes	Inserted catheter or port: Tenchoff, broviac, port cath, swan ganz, CVL (central line), epidural, etc.
☐ No ☐ Yes	IUD, Diaphragm, or Pessary
☐ No ☐ Yes	Metal rod, plates, screws, nails, pins, or wires
☐ No ☐ Yes	Medicine patch such as nicotine, nitroglycerine, birth control, hormone, pain, or transdermal
☐ No ☐ Yes	Neuro or vagal nerve stimulator including spinal stimulator
☐ No ☐ Yes	Orthodontic appliances: dental braces, spacers, palate expanders, or Herbst device
☐ No ☐ Yes	Radiation seeds or implants
☐ No ☐ Yes	Spinal fixation device, spinal fusion procedure
☐ No ☐ Yes	Spinal or ventricular shunt
☐ No ☐ Yes	Spinal or ventricular programmable shunt
☐ No ☐ Yes	If yes, have you made an appointment at the doctor's office 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 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 and 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 Identification

☐ Patient's Equipment is MRI Safe Equipment

Patient's Weight (kg) ______________

☐ Initial Screening: Interview Conducted.

☐ MRI Safe Oxygen Tank

☐ Screened with MRI Target Scanner

Patient's Height (cm) ______________

______________________ __________ __________

Signature of Screener **(MR Technologist must sign for all clinical exams)** **Date** **Time**