OrthoSouth MRI Safety Screening Form

Name: OrthoSouth Physician:

Gender: Weight: Age: DOB:

An MRI examination involves the use of a very strong magnet. For your safety, the presence of certain metallic objects must be determined before entering the exam room. If you answer yes to any implanted devices, please provide implant card and inform the MRI Technologist.

The following items may be harmful to you during your MRI scan and may interfere with the MRI exam. Please select YES or NO answer to every item listed.

Select	Cardiac Pacemaker/Defibrillator	Select	Tattoos(less than 6 weeks)/Magnetic Eyelashes
Select	Coil, Filter, Shunt, or Stent	Select	Claustrophobia
Select	Heart surgery or Implant	Select	Dentures or Partials
Select	Artificial Heart Valve	Select	Pregnant/ Breast Feeding
Select	Artificial Eye or Implant/Surgery Neck/	Select	IUD or diaphragm Type _____
Select	Back surgery	Select	Shrapnel/Bullets
Select	Aneurysm Clips	Select	Body/Ear piercings (Remove before MRI exam)
Select	Implanted/Removable Drug Pump	Select	Wig/Hair Implants or hair pins
Select	Cochlear Implant/Ear Implant Artificial	Select	Injury to Eye involving metal
Select	Limbs/Joint Replacement Monitoring	Select	Have you ever had Cancer? Type _____
Select	Device (e.g. glucose,Libre)	Select	Hearing Aids **(Remove before MRI Exam)**
Select	Brain Surgery/Implants	Select	Surgically Implanted Devices? Type _____
Select	Surgical Mesh	Select	Have you recently ingested a "pill cam"?
Select	Any type of internal electrodes or wires	Select	Electronic, Mechanical or Magnetic Implant
Select	Surgical Clips or Staples	Select	Medication Patches (e.g. nitroglycerine or nicotine)
Select	Penile Implant	Select	IV Access Port (e.g. Port-a-cath, Hickman, PICC)
Select	Stimulator (e.g. neurostimulator,deep brain,bone growth,spinal cord,etc.)		
Select	Any other surgically implanted devices, removable medical devices or personal items not covered above? **If yes, please list:**		

Please list any prior surgerys and approproximate dates: _____

_____

_____

Have you ever had surgery on the body part being scanned today? **Yes** ☐ **No** ☐

If yes, please describe injury: _____

_____

Approx. date when pain began: _____ Describe your pain: _____

I have read and understandthe entire content of this form:

Signature: _____ Date: _____ **SUBMIT**

Form completed by: Patient ☐ Relative ☐ Other ☐

TO BE COMPLETED BY MRI Technologist:

MR#: _____ Procedure: _____

MRI Technologist: _____ Date: _____