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.

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

Please list any prior surgery and approximate date(s): ______________________________________

____

____

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 understand the entire content of this form:

Signature: ____ Date: ______________

Form completed by: Patient Relative Other

TO BE COMPLETED BY MRI Technologist:

MR#: _________________________ Procedure: ____

MRI Technologist: ___________________________ Date: ___________________________