

St. Elizabeth Healthcare

MRI SAFETY CHECKLIST

Originated: 11/09 Revised: 05/11
Medical Record File No.: RAD M-15 Form No.: 10311 SEH

Please Check Yes or No to ALL of the following items:

- (If Yes, Call MRI)**
- Yes No Cardiac Pacemaker or Removal of a pacemaker
 Yes No Cardiac defibrillator or removal of a defibrillator
 Yes No Brain aneurysm clip or coil
 Yes No Internal electrodes or wires
 Yes No Aortic or aneurysm clip
 Yes No Zenith Endovascular Graft for AAA repairs?
 Yes No Valve Stent Coil Filter (please check)
 Yes No **WHEN** implanted: _____
 Yes No Electronic or magnetically activate implant or device
 Yes No Neurostimulator (TENS unit, etc)
 Yes No Spinal cord Stimulator
 Yes No Bone Stimulator
 Yes No Shunt: Spinal Ventricular (please check)
 Yes No Joint Replacements Body Part: _____
 Yes No Surgical Implants Such as Clip, Mesh, Staple, Pin, Magnet,
Screw, Wire, Rod
 Yes No Any prosthesis, including limbs, penile, or hair implants
 Yes No Cochlear, Otologic, or other ear implant
 Yes No Insulin pump or other infusion pump
 Yes No IV access port (Broviac, Port A Cath, Hickman)
 Yes No Hearing Aid(s) (Remove Before Sending)
 Yes No Body Piercing (Including ears) Location: _____
 Yes No IUD, Diaphragm, or Pessary
 Yes No Recent Tattoos or Permanent makeup (within 2 weeks)
 Yes No Artificial Eye or eyelid spring or any eye implants
 Yes No Shrapnel/bullets (Call MRI before sending)
 Yes No Metal Fragments in eye (penetrating eye injury)
 Yes No Claustrophobia

- Yes No Dentures or partial plates (Remove before sending)
 Yes No Transdermal Medication Patches
 Yes No Tissue expanders (i.e. breast)
 Yes No Pregnant, Date of last menstrual period: _____
- ADDITIONAL SCREENING FOR IN-PATIENT ONLY**
- Yes No Endotracheal Tube
 Yes No Swan-Ganz or Thermodilution Catheter (Remove Before Sending)
 Yes No Extraventricular Device
 Yes No Arterial Line Transducer (Remove Before Sending)
 Yes No Rectal Thermometer/Probe (Remove Before Sending)
 Yes No Esophageal Probe
 Yes No Tracheotomy Tube
 Yes No Guidewires

**If you answered yes to any of the above, call MRI before sending.
More information may need to be obtained.**

Note: You will be offered earplugs to wear or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Patient/POA/Family Member: _____

Date: ___/___/___

Phone number of POA/Family member: _____

If verbal consent 2 medical signatures must be obtained:

Second Signature: _____ Date: ___/___/___

For MRI Technologist Use Only:

Technologist Signature: _____

Date: _____ Time: _____