Appendix 2

SAFETY SCREENING FORM
FOR
MAGNETIC RESONANCE (MR) PROCEDURES

Date________ Name (first middle last)__________________________________

Female [  ] Male [  ] Age_____ Date of Birth_______ Height_______ Weight______

Why are you having this examination (medical problem)?______________________________

YES    NO

Have you ever had an MRI examination before and had a problem?   ____  ____

If yes, please describe_______________________________________

Have you ever had a surgical operation or procedure of any kind?   ____  ____

If yes, list all prior surgeries and approximate dates:

_________________________________________________________________________

Have you ever been injured by a metal object or foreign body (e.g., bullet, BB ____  ____ shrapnel)?

If yes, please describe_________________________________
Have you ever had an injury from a metal object in your eye (metal slivers, metal shavings, other metal object)?
  If yes, did you seek medical attention?
  If yes, describe what was found

Do you have a history of kidney disease, asthma, or other allergic respiratory disease?

Do you have any drug allergies?
  If yes, please list drugs

Have you ever received a contrast agent or X-ray dye used for MRI, CT, or other X-ray or study?

Have you ever had an X-ray dye or magnetic resonance imaging (MRI) contrast agent allergic reaction?
  If yes, please describe

Are you pregnant or suspect you may be pregnant?
Are you breast feeding?  

Date of last menstrual period____ Post-menopausal?
MR Hazard Checklist

Please mark on the drawings provided the location of any metal inside your body or site of surgical operation.

The following items may be harmful to you during your MR scan or may interfere with the MR examination. You must provide a “yes” or “no” for every item. Please indicate if you have or have had any of the following:

YES NO

_____ _____ Any type of electronic, mechanical, or magnetic implant

Type__________________

_____ _____ Cardiac pacemaker

_____ _____ Aneurysm clip

_____ _____ Implanted cardiac defibrillator

_____ _____ Neurostimulator
<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biostimulator</td>
<td>Biostimulator</td>
</tr>
<tr>
<td>Any type of internal electrodes or wires</td>
<td>Cochlear implant</td>
</tr>
<tr>
<td>Hearing aid</td>
<td>Implant drug pump (e.g., insulin, Baclofen, chemotherapy, pain medicine)</td>
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<tr>
<td>Halo vest</td>
<td>Spinal fixation device</td>
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<tr>
<td>Spinal fusion procedure</td>
<td>Any type of coil, filter, or stent</td>
</tr>
<tr>
<td>Any type of metal object (e.g., shrapnel, bullet, BB)</td>
<td>Artificial heart valve</td>
</tr>
<tr>
<td>Any type of ear implant</td>
<td>Penile implant</td>
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<tr>
<td>Artificial eye</td>
<td>Eyelid spring</td>
</tr>
<tr>
<td>Any type of implant held in place by a magnet</td>
<td>Any type of surgical clip or staple</td>
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<tr>
<td>Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, Picc line)</td>
<td>Medication patch (e.g., Nitroglycerine, nicotine)</td>
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<tr>
<td>Shunt</td>
<td></td>
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</tbody>
</table>
Artificial limb or joint

What and where

Tissue Expander (e.g., breast)

Removable dentures, false teeth or partial plate

Diaphragm, IUD, Pessary

Type

Surgical mesh

Location

Body piercing

Location

Wig, hair implants

Tattoos or tattooed eyeliner

Radiation seeds (e.g., cancer treatment)

Any implanted items (e.g., pins, rods, screws, nails, plates, wires)

Any hair accessories (e.g., bobby pins, barrettes, clips)

Jewelry

Any other type of implanted item

Type

Instructions for the Patients
1. You are urged to use the ear plugs or headphones that we supply for use during your MRI examination since some patients may find the noise levels unacceptable, and the noise levels may affect your hearing.

2. Remove all jewelry (e.g., necklaces, pins, rings).

3. Remove all hair pins, bobby pins, barrettes, clips, etc.

4. Remove all dentures, false teeth, partial dental plates.

5. Remove hearing aides.

6. Remove eyeglasses.

7. Remove your watch, pager, cell phone, credit and bank cards and all other cards with a magnetic strip.

8. Remove body piercing objects.

9. Use gown, if provided, or remove all clothing with metal fasteners, zippers, etc.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form, and I have had the opportunity to ask questions regarding the information on this form.

Patient signature_____________________________

MD/RN/RT signature_________________________   Date___________

Print name of MD, RN, RT_______________________
For MRI Office Use Only

Patient Name______________________________________________________________

Patient ID Number_______________      Referring Physician_______________________

Procedure_________________________ Diagnosis___________________________

Clinical History__________________________________________________________

**Hazard Checklist for MRI Personnel**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th></th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Endotracheal tube</td>
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<tr>
<td></td>
<td></td>
<td>Swan-Ganz catheter</td>
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<tr>
<td></td>
<td></td>
<td>Extra ventricular device</td>
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<tr>
<td></td>
<td></td>
<td>Arterial line transducer</td>
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<td></td>
<td></td>
<td>Foley catheter with temperature sensor and/or metal clamp</td>
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<td></td>
<td></td>
<td>Rectal probe</td>
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<tr>
<td></td>
<td></td>
<td>Esophageal Probe</td>
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<td></td>
<td></td>
<td>Tracheotomy tube</td>
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</table>
____  ____  Guidewires