Open MRI of FREMONT

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MRI Screening Questionnaire

Name: _____ Date: _____

Sex: _____ Age: _____ Weight: _____ Patient Account Number: _____

This questionnaire is designed to assist us in determining if it is safe for you to undergo a magnetic resonance imaging procedure. It is important that you answer all of the following questions. **If you don't understand any question, please ask for assistance.**

		YES	NO	DON'T KNOW
1.	Do you have a cardiac pacemaker, wires, implanted cardioverter defibrillator, or implanted heart valves?	☐	☐	☐
2.	Have you ever had any head surgery requiring aneurysm clips?	☐	☐	☐
3.	Do you have any surgically implanted metal of any type in your body (such as metal pins, prosthesis, internal electrodes, shunt, wire mesh implant, implanted drug infusion device, eyelid spring)?	☐	☐	☐
4.	Have you ever been exposed to metal fragments that could be lodged in your eyes or body?	☐	☐	☐
5.	Do you have or have you ever had tattoos, tattooed eyeliner, lipliner or body piercing?	☐	☐	☐
6.	Do you wear a transdermal medication patch (nitroglycerin or nicotine)?	☐	☐	☐
7.	Do you have surgical staples, clips or metallic sutures?	☐	☐	☐
8.	Have you ever experienced claustrophobia?	☐	☐	☐
9.	Do you have a hearing aid (remove before entering MR system room)?	☐	☐	☐
10.	If you are a woman – are you pregnant, or is it possible that you might be pregnant?	☐	☐	☐
11.	Is there any other item or device you believe we should know about prior to performing the procedure – if yes, please describe.			

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I certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform the Center of any metal fragments and/or devices that may be in my body, and that by failing to do so may cause serious bodily injury or be life threatening. I agree that should I have any metal in my body and, after consultation with a physician, elect to proceed with the MRI, I agree to release Center from any and all liability for any injury.

_____	_____	_____
Patient or Legal Representative Signature	Print Name and Authority (if legal representative)	Date
_____	_____	_____
Witness or Interpreter Signature	Print Name	Date
_____	_____	_____
Physician/Registered Nurse/Technologist	Print Name and Title	Date

Technologist Notes _____

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