UNIVERSITY OF VIRGINIA HEALTH SYSTEM
MRI Screening for Outpatients

Date: __________________
If no label write in name and MRN

Height: _______________ Weight: ________________

WARNINGs AND IMPORTANT INSTRUCTIONS

!!MAGNET IS ALWAYS ON!!

Certain implants and devices may be hazardous to you and/or may interfere with the MR procedure. Do not enter
The MR system room if you have any questions regarding an implant, device, or object. Before entering the MR
environment you must remove all metallic objects including hearing aids, dentures, partial plates, keys, pager, cell
phone, hairpins, jewelry, body piercing jewelry, watch, safety pins, credit cards, (any card with a magnetic strip),
pocket knife, nail clippers, and tools. Consult the MR technologist BEFORE entering the MR system room!

Do you have any allergies? (if yes please list on back of form)...... Yes No
Have you ever had any surgery? (if yes please list on back of form) Yes No
Have you ever had an MRI? ................................................................. Yes No
Do you have claustrophobia? .......................................................... Yes No
Have you ever had IV or oral contrast material for a MRI exam? ...... Yes No
If yes, did you have any discomfort, ill effects or allergic reaction? Yes No
Do you have trouble lying down for 45 minutes or more?................. Yes No
Do you have heart or vascular disease? .......................................... Yes No
Do you have asthma? ................................................................. Yes No
Is there a chance you may be pregnant? ......................................... Yes No
Are you breast feeding? ............................................................... Yes No
Do you have a history of kidney disease? ........................................ Yes No
Do you have diabetes? ................................................................. Yes No
Are you on dialysis? .................................................................... Yes No
If on dialysis when is your treatment? ______________________________

Please indicate if you have any of the following:

Do you have breathing difficulties while lying down? ...................... Yes No
Do you have surgical staples, clips, or metallic sutures? ................. Yes No
Do you have a vascular access port or catheter? .............................. Yes No
Do you have a heart valve prosthesis? ........................................... Yes No
Are you wearing a medication patch? (i.e. Nicotine, Nitroglycerine) Yes No
Do you have an artificial or prosthetic limb? ................................. Yes No
Do you have an IUD, diaphragm, or peccary? ................................. Yes No
Do you have a joint replacement (hip, knee etc) or bone/joint pin? Yes No
Do you have dentures or partial plates? ......................................... Yes No
Do you have a tattoo or permanent makeup? ................................. Yes No
Do you have any body piercing jewelry? ....................................... Yes No
Do you have an electronic implant or device? ............................... Yes No
Do you have any radiation seeds or implants? ............................... Yes No
Do you have a hearing aid? ............................................................ Yes No
Do you have a wire mesh implant? ................................................ Yes No
Do you have any other implant? (if yes, please list on back of form) Yes No
MR Scan can most likely be done with these objects:

- Do you have any type of prosthesis (eye, penile, etc)?
  - [ ] Yes
  - [ ] No

- Do you have an eyelid spring or wire?
  - [ ] Yes
  - [ ] No

- Do you have a metallic stent, filter, or coil?
  - [ ] Yes
  - [ ] No

If yes, please list location, make and model and date of insertion

- Do you have any metallic fragments or foreign body? (e.g., shrapnel, bullet or BB)
  - [ ] Yes
  - [ ] No

Items that may or may not be MRI conditional:

- Do you have an aneurysm clip(s)?
  - [ ] Yes
  - [ ] No

- Do you have an ICP bolt?
  - [ ] Yes
  - [ ] No

- Do you have an electronic, mechanical or magnetic implant?
  - [ ] Yes
  - [ ] No

- Do you have a neuro-stimulator, DBS or VNS?
  - [ ] Yes
  - [ ] No

- Do you have a spinal cord stimulator?
  - [ ] Yes
  - [ ] No

- Do you have internal electrodes or wires?
  - [ ] Yes
  - [ ] No

- Do you have a bone growth or bone fusion stimulator?
  - [ ] Yes
  - [ ] No

- Do you have a cochlear or other ear implant?
  - [ ] Yes
  - [ ] No

- Do you have an implanted insulin or other infusion or pain pump?
  - [ ] Yes
  - [ ] No

- Do you have a shunt (spinal or ventricular)?
  - [ ] Yes
  - [ ] No

- Do you have a tissue expander?
  - [ ] Yes
  - [ ] No

These items are generally contraindicated for MRI:

- Have you ever had an injury to your eye involving metallic object or fragment?
  - [ ] Yes
  - [ ] No

- Do you have a cardiac pacemaker or implanted cardio defibrillator?
  - [ ] Yes
  - [ ] No

- Do you have a Swan-Gantz or thermo dilution catheter?
  - [ ] Yes
  - [ ] No

Please list the types and dates of surgeries, list and describe allergies, list the model and date of insertion for any implants or stents below.

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Information reviewed by:

Performing Technologist:___________________________________________________

Supporting Staff (Tech or Clinical Assoc.):______________________________________

Entered into EPIC by:__________________________________________________________