

MRI SAFETY DATA SHEET

NAME:	DOB:
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PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

All "YES" answers will to be checked by the technologist to insure your safety before an MRI

	YES	NO
Pacemaker		
Temporary Pacemaker		
Aneurysm Clips:		
Cerebral		
Aortic		
Pregnant		
I.U.D		
Infusion Pump		
Replacement Heart Valve		
Neurostimulator		
Cochlear Implant		
Shrapnel		
Bone Growth/ Fusion Stimulator		
Swan-Ganz Catheter		
Tattooed Makeup		
Internal Pacing Wires		
Harrington Rods (Back)		

	YES	NO
Intravascular Coil, Filter or Stent		
Penile Implant		
Implanted Cardiac Defibrillator		
Vascular Access Port		
Magnetic Implants		
Orbital / Eye Prosthesis		
Any type of surgical clip or staple		
Ortho pins, Screws, etc...		
External Hearing Aid		
Braces (Dental or Ortho)		
Prosthesis		
Carotid Artery Vascular Calmps		
Shunt (Spinal or Intraventricular)		
Transdermal Patch		
Body Piercing (s)		
Metal or Wire Mesh Implants		
Metal Rods in Bones		

Have you been employed as a metal worker or had metal in your eyes? YES_____ NO_____

PLEASE EXPLAIN ALL "YES" ANSWERS: _____

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

Signature of Person Completing Form

____/____/____
Date

_____lb.
Pt. Weight

Are you claustrophobic? Yes___ No___
Breathing Disorder? Yes___ No___
Surgery, less then 6 weeks? Yes___ No___

Motion Disorder? Yes___ No___
Are You Breast Feeding? Yes___ No___