UCLA Health System

MRN:
Patient Name:

(Patient Label)

MRI SAFETY SCREENING QUESTIONNAIRE (OUTPATIENTS)

Sex:_____ **Age:**_____ **Height**:_____ **Weight:**_____

The following items may be harmful to you during your MR scan or may interfere with the MR examination. Please provide a "yes" or "no" answer for every item.

YES	NO	
☐	☐	Cardiac pacemaker or implanted cardioverter defibrillator/ICD
☐	☐	Internal electrodes or wires (pacing wires, DBS or VNS wires)
☐	☐	Artificial heart value, coil, filter and/or stent (Gianturco coil, IVC filter)
☐	☐	Aneurysm clip(s)
☐	☐	Neurostimulator-TENS Unit, Biostimulator, bone growth stimulator, DBS, VNS
☐	☐	Implanted drug pump (for chemotherapy medicine, pain medicine)
☐	☐	External drug pump (for Insulin or other medicine)
☐	☐	IV access port (Port-a-Cath, Broviac, PICC line, Swan-Gantz, Thermodilution)
☐	☐	Implanted post surgical hardware (pins, rods, screws, plates, wires)
☐	☐	Artificial joint and /or limb
☐	☐	Artificial eye and/or eyelid spring
☐	☐	Eye injury from a metal object (metal shavings, metal slivers)
☐	☐	Ear (Cochlear) implant, middle ear implant
☐	☐	Hearing aid(s)
☐	☐	False teeth/dentures, metallic removable dental work, braces, retainers
☐	☐	Any type of implant held in place by a magnet
☐	☐	Injured by a metal object (shrapnel, bullet, BB) and required medical attention
☐	☐	Medication patch (nitroglycerine, nicotine, contraceptive, estrogen)
☐	☐	Shunt or Sophy adjustable and programmable pressure valve
☐	☐	Spinal fixation device, spinal fusion and/or halo vest, spinal cord stimulator
☐	☐	Surgical clips, staples or surgical mesh
☐	☐	Tissue expander (breast)
☐	☐	Penile implant
☐	☐	Pessary, IUD, Diaphragm
☐	☐	Radiation seeds (cancer treatment)
☐	☐	Body piercing, tattoo or permanent makeup
☐	☐	Wig, hair implants

Do you have a history of:

YES	NO		YES	NO	
☐	☐	Kidney disease	☐	☐	Latex Allergy
☐	☐	Diabetes	☐	☐	Allergic reaction to MRI contrast (Gadolinium based)
☐	☐	Liver disease			
☐	☐	Claustrophobia			
☐	☐	Drug Allergy, Type: _____			

Are you on dialysis? ☐ YES ☐ NO If YES, Hemodialysis or Peridialysis? (circle one)

Female Patients:

Are you pregnant? ☐ YES ☐ NO Are you breast-feeding ☐ YES ☐ NO

If you are still menstruating, please provide the date of your last period_____

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If you answered **YES** to any of the questions on the front page, please discuss any concerns and/or issues you may have, with your MR Technologist, MR Assistant or Radiology Nurse.

Instructions for the Patient, Parent, Guardian:
We will provide a locker so **ALL** items you remove may be stored and locked safely during your scan. You may bring the key in the scan room with you.

1. Remove **ALL** jewelry and **ALL** body piercing jewelry and **ALL** hair accessories.
2. Remove dentures, false teeth, partial dental plates, retainers.
3. Remove hearing aids and eyeglasses.
4. Remove **ALL** clothing and change into a hospital gown. Slippers will be provided.
5. Lock your clothes and valuables in the locker provided and remove the key.
6. Please use the restroom before your MRI exam.
7. Please make sure that you receive a pair of earplugs and/or the headphones before your MRI exam begins. Some patients may find the noise levels unacceptable, and the noise levels may affect your hearing.

I attest 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/Parent/Guardian/Other Signature Date Time

_____ _____ _____
MR Tech/MR Assistant/RN Signature Date Time

_____
Print Name of MR Tech/MR Assistant/RN

FOR MRI STAFF USE ONLY

CONTRAST ORDER/SIGNATURE	To Be Filed in the Medical Record

Contrast Type:_____ Injection Rate:_____ Injection Amount: _____

Creatinine Value: _____ GFR Value: _____ Date Acquired _____

Creatinine/GFR screening waived by: _____

MR Technologist/RN/MD Signature: _____ Date: _____ Time: _____

Radiologist Signature: _____ Date: _____ Time: _____