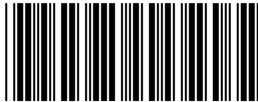
**Lucile Salter Packard Children's Hospital**
STANFORD UNIVERSITY MEDICAL CENTER
725 Welch Road Palo Alto, CA 94304



DIAGNOSTIC TESTS • MRI SCREENING FORM

Medical Record Number

Patient Name

Addressograph or Label

Date: __________ Phone/Cell number: ________________ ❑ New Patient to MRI ❑ Current or return patient
Name: ___________________________ Birth date: _____________ Height:___________ Weight: __________

1. Have you ever had surgery or other invasive procedures? ❑ No ❑ Yes If yes, please list below.
   Type:_______________________________________ Date:_______/________/________
   Type:_______________________________________ Date:_______/________/________
2. Have you ever worked with metal (grinding, fabricating, etc.) or ever had an injury to the eye involving a metallic object ( e.g., metallic silvers, shavings, BBs or pellots)? ❑ No ❑ Yes
   If yes, please describe: ____________________________________________
3. Are you pregnant or experiencing a late menstrual period? ❑ No ❑ Yes

**Warning:** Some of the following items may be **extremely** hazardous to your safety and some can interfere with the MRI examination. Please check No or Yes if you have the following.

| | | | |
|---|---|---|---|
| ❑ No ❑ Yes | Cardiac pacemaker | ❑ No ❑ Yes | Shrapnel, buckshot, or bullets |
| ❑ No ❑ Yes | Implanted cardiac defibrillator | ❑ No ❑ Yes | IUD or diaphragm |
| ❑ No ❑ Yes | Aneurysm clip or brain clip | ❑ No ❑ Yes | Pessary of bladder ring |
| ❑ No ❑ Yes | Carotid artery vascular clamp | ❑ No ❑ Yes | Tattooed eyeliner or eyebrows |
| ❑ No ❑ Yes | Neurostimulator | ❑ No ❑ Yes | Body piercing(s) |
| ❑ No ❑ Yes | Insulin or infusion pump | ❑ No ❑ Yes | Metal fragments (eye, head, ear, skin) |
| ❑ No ❑ Yes | Implanted drug infusion device | ❑ No ❑ Yes | Facelift or other cosmetic surgery |
| ❑ No ❑ Yes | Spinal fusion stimulator | ❑ No ❑ Yes | Internal pacing wires |
| ❑ No ❑ Yes | Cochlear, otologic, or ear implant | ❑ No ❑ Yes | Aortic clips |
| ❑ No ❑ Yes | Ear tubes | ❑ No ❑ Yes | Venous umbrella |
| ❑ No ❑ Yes | Prosthesis (eye/orbital, penile, etc.) | ❑ No ❑ Yes | Metal or wire mesh implants |
| ❑ No ❑ Yes | Implant held in place by a magnet | ❑ No ❑ Yes | Wire sutures or surgical staples |
| ❑ No ❑ Yes | Heart valve prosthesis | ❑ No ❑ Yes | Harrington rods (spine) |
| ❑ No ❑ Yes | Artificial limb or joint | ❑ No ❑ Yes | Metal rods in bones; joint replacemer |
| ❑ No ❑ Yes | Other implants in body or head | ❑ No ❑ Yes | Bone/joint pin, screw, nail, wire plate |
| ❑ No ❑ Yes | Electrodes (on body, head or brain) | ❑ No ❑ Yes | Wig, toupee, or hair implants |
| ❑ No ❑ Yes | Intravascular stents, filters, or coils | ❑ No ❑ Yes | Hearing aid (Remove before scan) |
| ❑ No ❑ Yes | Shunt (spinal or intraventricular) | ❑ No ❑ Yes | Dentures (Remove before scan) |
| ❑ No ❑ Yes | Vascular access port or catheters | ❑ No ❑ Yes | Asthma or breathing disorders |
| ❑ No ❑ Yes | Swan-Ganz catheter | ❑ No ❑ Yes | Renal or Kidney problems |
| ❑ No ❑ Yes | Transdermal medication patch(es) | ❑ No ❑ Yes | Seizures or motion disorders |
| | (Remove before scan) | ❑ No ❑ Yes | Claustrophobia |

**IMPORTANT INSTRUCTIONS:** Remove all metallic objects before entering the MR environment or MR system room including hearing aids, beeper, cell phone, keys, eyeglasses, hair pins, barrettes, jewelry (including body piercing jewelry), watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail cliper, steel-toed boots/shoes, and tools. Loose metallic objects are especially prohibited in the MR system room and MR environment.
**Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.**

**Earplugs are required during the MRI examination.**

_______________________________________________ Date: _____/_____/____
Signature of person completing form

Form completed by: ❑ Patient ❑ Relative: ______________________________
Print Name & relationship to patient

❑ Physician or other: ______________________________
Print Name & relationship to patient

| DATE TIME | Reviewed by: ❑ MRI Technologist ❑ Radiologist | |
|---|---|---|
| | **PRINT** Name: | ❑ SAFESCAN INITIALS:_________ |