

Weiss Medical Associates Open MRI

MRI Safety Checklist

Patient Name: _____ Date: _____

Date of Birth: _____ Male/Female _____ Weight: _____ Height: _____
(Circle One)

Have you ever had surgery on the area to be scanned? Yes _____ No _____
List all previous surgeries: _____

Have you ever been treated or diagnosed for cancer? Yes _____ No _____
If yes please explain type and treatment _____

Have you ever worked or been exposed to an environment in which you may have been exposed to metal slivers in your eye or body? (i.e. worked in a machine shop, metals shop etc.) Yes _____ No _____

Please check all that currently apply:

Metal in Eyes	Yes _____	No _____
Intracranial Aneurysm Clips	Yes _____	No _____
Cardiac Pacemaker	Yes _____	No _____
Metal Fragments (Inracranial/Intraorbital)	Yes _____	No _____
IVC Filter (Inferior Vena Cava)	Yes _____	No _____
Electronic Implants (I.E. cochlear)	Yes _____	No _____
IUD, Diaphragm, Penile Implant	Yes _____	No _____
Neurostimulators	Yes _____	No _____
Infusion Pumps (Insulin, Chemo)	Yes _____	No _____
Cardiac Valve Prosthesis	Yes _____	No _____
Pregnant	Yes _____	No _____
Permanent Eye Lining (Tatoing of eyelid)	Yes _____	No _____
Body Piercing	Yes _____	No _____
Medicated Patches	Yes _____	No _____
Stents	Yes _____	No _____

Did you have a Creatin blood draw for today's exam? Yes _____ No _____

Patient, please read and initial: I acknowledge that I have read and understand this safety checklist and have answered truthfully, to the best of my ability, the questions described herein. Patient Initial: _____

Previous MRI: Yes: _____ No: _____ If yes which body part? _____

Date of Scan: _____ Facility: _____

Patient Signature: _____

Musical Selection from Playlist: _____