BAYLOR RADIOLOGISTS
a radiology partners affiliated practice

Department of
Diagnostic & Therapeutic Radiology

MRI Safety Form

Patient Identification Label

Last Name:	First: M.I.	Height:
Today's Date:	Date of Birth:	Weight:

Form Revised July 2020

This section to be completed by nurse or patient/patient's representative:
If any of the following items are answered "yes", MRI must be informed before the procedure is scheduled

Question				
1. **Does the patient have a pacemaker / ICD?**	**STOP! CAN'T HAVE MRI!**	☐ No	☐ Yes	____ staff initial
2. **Has the patient had an invasive procedure?**	**STOP!**	☐ No	☐ Yes	____ staff initial
3. **Do you have an intracranial aneurysm clip?**	**STOP!**	☐ No	☐ Yes	____ staff initial
4. **Do you have a neurostimulator/deep brain stimulator?**	**STOP!**	☐ No	☐ Yes	____ staff initial
5. **Do you have an implanted infusion pump?**	**STOP!**	☐ No	☐ Yes	____ staff initial
6. **Do you have a temperature probe?**	**STOP!**	☐ No	☐ Yes	____ staff initial
7. **Do you have a Swanz Ganz catheter or IABP?**	**STOP!**	☐ No	☐ Yes	____ staff initial

If YES is checked on any of the questions below please contact the MRI department ext. 5-6250

__Yes __ No Carotid artery vascular clamp
__Yes __ No Implanted drug infusion pump
__Yes __ No Bone growth/fusion stimulator
__Yes __ No Ear/Eye implant
__Yes __ No History of eye injuries
__Yes __ No Penile implant
__Yes __ No Heart Valve prosthesis
__Yes __ No Any metal hardware in spine or bones
__Yes __ No Electrodes (on body, head or brain)
__Yes __ No Vascular stents, filters, or coils
__Yes __ No Shunt (spinal or intraventricular)
__Yes __ No Vascular access port and/or catheter
__Yes __ No Medication patch
__Yes __ No IUD or diaphragm
__Yes __ No Tattooed makeup (eyeliner, lips, etc.)
__Yes __ No Bullets/BB's/Pellets/Shrapnel/Metal fragments
__Yes __ No Hearing aid (**REMOVE BEFORE MRI**)
__Yes __ No Dentures (**REMOVE BEFORE MRI**)
__Yes __ No Motion disorder
__Yes __ No Claustrophobia
__Yes __ No Pill Cam capsule
__Yes __ No Radiation seeds or implants
__Yes __ No Removable pumps (**REMOVE BEFORE MRI**)
__Yes __ No Implanted device of any type?

Other, please explain: ______________________________
____
____

Please mark on the figure below, the location of any implant or metal inside of or on your body.

RIGHT **LEFT**

Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, body piercings, watch, safety pins, paper-clips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife & clothing with metal in the material.

NOTE: Patients are required to wear earplugs or ear-phones during the MRI examination. Please notify technologist if you experience warm sensations during the scan. Individuals remaining in the scan room during the exam must wear earplugs.

1. Have you ever had surgery or an invasive procedure? If yes, please list: ☐ No ☐ Yes
   Type:____ Date:_______________
   Type:____ Date:_______________
2. Have you had any previous MRI studies? If yes, please identify: ☐ No ☐ Yes

BODY PART	DATE	FACILITY / LOCATION

3. Do you have drug allergies to drugs, CT or MRI Contrast? If yes, list: ____________________ ☐ No ☐ Yes
   ____
4. Have you ever had asthma? ☐ No ☐ Yes
   ____
5. Are you on dialysis, or have kidney problems/ End Stage Renal Disease? ☐ No ☐ Yes
   ____

FEMALE PATIENTS

1) Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes
2) Date of last menstrual period:_________________ Are you breast feeding? ☐ No ☐ Yes
3) Are you taking any type of fertility medication or having fertility treatments? ☐ No ☐ Yes

Form Completed by: ☐ Patient ☐ Relative ☐ Physician ☐ Other

X______________________________ _____ _____
Signature of Person Completing Form date time

X______________________________
Print Name and Relationship to Patient

I have discussed the form with the patient and reviewed any "yes" answered questions if applicable. ______________

Initials **MRI Technologist Signature** date time **Print MRI Technologist Name**

Initials **Radiologist [Metal Approval]** date time **Print Radiologist [Metal Approval] Name**

A handoff has been performed between technologists with regard to screening and patient information

Initials **Sending MRI Tech Signature** date time **Initials** **Receiving MRI Tech Signature** date time

____________ **(MRI Staff)** **Patient's prior SLEH Studies checked on PACS.**

FAX# 832-355-7401