



32615 US Hwy 19 N Suite #4 Palm Harbor FL 34684

MRI Safety Questionnaire and Instructions for MRI/MRV/MRCP & MR Arthrogram

Please provide a "yes" or "no" answer for every item.

- | | | | | | |
|------------------------------|-----------------------------|--------------------------------------|------------------------------|-----------------------------|-------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cardiac pacemaker/defibrillator/ICD | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aneurysm clip(s)/metal stent |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Internal electrodes or wire | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone growth stimulator, DBS, VNS |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Magnetic implant or IVC Filter | <input type="checkbox"/> Yes | <input type="checkbox"/> No | External drug pump |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Spinal fusion and/or halo vest | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any chance you are pregnant |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ear implant, middle ear implant | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Medication patch |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted drug pump/insulin pump | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wigs, hair implants |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tissue expander (breast) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing Aid(s) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eye injury from a metal object | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ankle monitor |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Injured by metal (shrapnel,bullet) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial eye and/or eyelid spring |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurostimulator or Biostimulator | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shunt/Sophy pressure valve |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Spinal fixation device or stimulator | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any metal inside or outside of body |

Instructions for the Patient, Parent, Guardian:

1. Remove all jewelry and all body piercing jewelry and all hair accessories.
2. Remove all dentures, partial dental plates, retainers (for brain, head or neck examinations).
3. Remove hearing aids and eyeglasses and bobbie pins.
4. Remove wallet and anything in your pockets.
5. Remove wigs (for brain, head or neck examinations).
6. Lock your clothes and valuables in the locker or room provided and remove the key.

I attest the above information is correct. I have read and understand the entire contents of this form.

Patient/Parent/Guardian/Other Signature: _____ **Date:** _____