

**M.R.I. AND X-RAY SCREENING FORM**

PATIENT NAME: \_\_\_\_\_ CHART #: \_\_\_\_\_

**THE FOLLOWING ITEMS MAY BE HAZARDOUS OR MAY INTERFERE WITH THE MRI EXAMINATION BY PRODUCING ARTIFACT.**

**PLEASE INDICATE IF YOU HAVE THE FOLLOWING:**

Cardiac Pacemaker	Yes _____	No _____
Aneurysm Clips	Yes _____	No _____
Implanted Defibrillator	Yes _____	No _____
Implanted Insulin Pump	Yes _____	No _____
Electronic or Mechanical Implant	Yes _____	No _____
Hearing Aid	Yes _____	No _____
Heart Valve Prosthesis	Yes _____	No _____
Shrapnel, Bullets, or B.B.'s	Yes _____	No _____
Any type of Ear Implants	Yes _____	No _____
Orbital / Eye Prosthesis	Yes _____	No _____
Any type of Implant held in place by a Magnet	Yes _____	No _____
Any type of Surgical Clip or Staple	Yes _____	No _____
Vascular Access Port	Yes _____	No _____
Intraventricular Shunt / Stent	Yes _____	No _____
Artificial Limb or Joint	Yes _____	No _____
Dentures	Yes _____	No _____
Diaphragm or I.U.D.	Yes _____	No _____
Wire Mesh	Yes _____	No _____
Any Implanted Orthopedic Item (Pins, Rods, Screws, Etc.)	Yes _____	No _____
Any other Implanted Item	Yes _____	No _____
Tattooed Eyeliner	Yes _____	No _____

**List any previous surgeries with dates:**

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I attest that 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 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Technologist Initials: \_\_\_\_\_

March 2016