SWEDISH MRI SAFETY SCREENING FORM

WARNING! Before entering the MRI environment, you must remove **all** metallic objects (hearing aids, dentures, cell phone, glasses, hair pins, watch, safety pins, money clip, credit cards, pens, pocket knives, etc.). For your safety, you are required to wear a hospital provided gown as some clothing can cause burns in MRI. Please consult with the MRI Technologist if you have any questions **BEFORE** you enter the MRI room.

PATIENT INFORMATION

Height: ____________ **Weight:** ____________ **When do you follow up with your Doctor?** ______________________________

Do you have or have you ever had any of the following?

- ☐ Yes ☐ No Cardiac Pacemaker / Defibrillator
- ☐ Yes ☐ No Heart Surgery / Artificial Heart Valve
- ☐ Yes ☐ No Ventricular Assist Device (VAD)
- ☐ Yes ☐ No Internal Wires or Electrodes
- ☐ Yes ☐ No Brain Aneurysm Clips or Coils
- ☐ Yes ☐ No Electrical Nerve / Bone Stimulator
- ☐ Yes ☐ No Shunt
- ☐ Yes ☐ No Eye Implants / Spring / Wire / Retinal Tack
- ☐ Yes ☐ No Cochlear (ear) Implants / Stapes Prosthesis
- ☐ Yes ☐ No Implanted Insulin, Drug, or Infusion pump
- ☐ Yes ☐ No Stent, Filter, or Coil in a vessel
- ☐ Yes ☐ No Electrical, Mechanical, or Magnetic implant
- ☐ Yes ☐ No Ortho Pins / Screws / Rods / Joints / Prosthesis
- ☐ Yes ☐ No Tissue Expander (e.g. breast)
- ☐ Yes ☐ No Prostate seeds / Penile implant
- ☐ Yes ☐ No Gunshot wounds / Shrapnel / BB
- ☐ Yes ☐ No Implanted contraceptives (IUD)
- ☐ Yes ☐ No Medication patch / Silver dressing
- ☐ Yes ☐ No Tattoo / Permanent makeup / Body piercing
- ☐ Yes ☐ No Hearing aids / Dentures / Partials
- ☐ Yes ☐ No Hair extensions / Hair piece / Wig
- ☐ Yes ☐ No Injury to the eye involving metal fragments
- ☐ Yes ☐ No Other implant not listed ______________________________
- ☐ Yes ☐ No Are you p regnant or breastfeeding?
- ☐ Yes ☐ No Are you claustrophobic?
- ☐ Yes ☐ No History of anxiety disorder?

Please explain all YES answers: ______________________________

List any Drug/Contrast Allergies: ______________________________

List any Previous Surgeries: ______________________________

Please circle any personal history of: Diabetes / High Blood Pressure / Kidney Disease / Liver Disease Cancer / Tumors / Multiple Myeloma / Advanced Congestive Heart Failure (CHF) / Sickle Cell Anemia / Dialysis

Have you had Chemotherapy in the last 30 days? ❐ Yes ❐ No

Had an esophageal pH test (acid reflux Bravo chip) or capsule endoscopy (pill camera) in last 30 days? ❐ Yes ❐ No

Have you ever had MRI contrast? ❐ Yes ❐ No Allergic reaction? ❐ Yes ❐ No If yes, pre-medicated? ❐ Yes ❐ No

I attest that the above information is correct to the best of my knowledge.

Signature	Date / Time	Print Name of Patient/Parent/Representative	Relationship to Patient

FOR IP / ED RN USE ONLY

Form must be completed & faxed to MRI before patient will be transported to MRI
Patient must be able to cooperate for the exam

- ☐ Yes ☐ No Is patient stable, cooperative, able to lie flat and hold still for the MRI?
- ☐ Yes ☐ No Is patient claustrophobic, in pain, or have anxiety disorder? If YES, is premedication ordered? ❐ Yes ❐ No
- ☐ Yes ☐ No Is an interpreter needed? Language: ____________________
- ☐ Yes ☐ No Does patient have IV access? Size: __________ Location: __________ ❐ Port or PICC ❐ Power PICC
- ☐ Yes ☐ No Does patient have eGFR within last 24 hours? eGFR: ______________ Date: ____________
- ☐ Yes ☐ No Does patient have a Swan-Ganz Line or a Temperature-sensing Foley?
- ☐ Yes ☐ No Is patient on a ventilator?
- ☐ Yes ☐ No Have all foil-backed lead and EKG patches, medication patches and dressings (i.e. Acticoat) been removed?
- ☐ Yes ☐ No Is patient in hospital gown, all street clothes, bra, jewelry, watch, accessories removed? **(Required for MRI)**
- ☐ Yes ☐ No Has the Safety Screening Form been completed and signed by patient, appropriate family, or legal guardian?
- ☐ Yes ☐ No Is continued infusion required? If yes, RN must switch to MRI SAFE pump
- ☐ Yes ☐ No Does patient need to be monitored? If YES, RN is required for monitoring

RN Name: ____________________ Signature: ____________________ Date/Time: ____________________

MRI

❐ ID / Screening Form Verified ❐ Verbally / Visually Screened ❐ Safety Pause eGFR: ____________ Date: ____________

Notes: ______________________________ Signature: ______________________________ Date: ____________

Patient Label