RADIOLOGY ASSOCIATES OF WAUSAU, S.C.

OPEN MRI OF WAUSAU

MAGNETIC RESONANCE IMAGING (MRI) SAFETY RECORD

Name: _____ Birth Date: _____

Describe any symptoms you are having: _____

_____

Have you had surgery in the area being scanned? ☐ YES ☐ NO

Facility: _____ Date: _____

Have you had a previous MRI of this area? ☐ YES ☐ NO

Facility: _____ Date: _____

Were there any x-rays taken for this problem? ☐ YES ☐ NO

Trauma/Injury to area being scanned? ☐ YES ☐ NO

Have you ever been diagnosed with any of the following?

Kidney Disease / Decreased Function?	☐ YES	☐ NO
On Dialysis?	☐ YES	☐ NO
High Blood Pressure?	☐ YES	☐ NO
Diabetes?	☐ YES	☐ NO
Insulin Dependent?	☐ YES	☐ NO
Cancer?	☐ YES	☐ NO

Type: _____

Height: _____

Weight: _____

GFR: _____

LMP: _____

PLEASE COMPLETE THE FOLLOWING CHECKLIST

(Please hold any questions for the MRI Technologist)

YES	NO	
☐	☐	Can you lie on your back for at least 45 minutes?
☐	☐	Are you claustrophobic or afraid of small places?
☐	☐	Have you ever been a machinist, welder, or metal-worker?
☐	☐	Have you ever been hit in the face or eye with a piece of metal? (Including metal shavings, slivers, bullets or BB's)
☐	☐	Are you pregnant, possibly pregnant, or breast feeding?

DO YOU HAVE ANY OF THESE ITEMS IN OR ON YOUR BODY? (Explain YES answers)

☐	☐	Cardiac Pacemaker, Pacer Wires, Defibrillator (ICD)
☐	☐	Brain Surgery/Brain Aneurysm Clip
☐	☐	Ear Implant/Inner Ear Surgery/Cochlear Implant, Etc.
☐	☐	Eye Implant/Eye Surgery/Eyelid Spring or Wire
☐	☐	Electrical Stimulator/Tens Unit/Electronic Implant/Device
☐	☐	Bullets/BB's/Pellets/Shrapnel/Fragments – If yes, where:
☐	☐	Implanted Medication Pump/Infusion Pump/Device
☐	☐	Stimulator System: Neuro, Spinal, Bladder, Bone
☐	☐	Magnetically-Activated Implant/Device
☐	☐	Shunt (Spinal or Intraventricular)
☐	☐	Artificial Limb/Joint/Prosthesis (e.g., Plates, Screws, Pins, Rods)
☐	☐	Coil/ Filter/Stent in Blood Vessel
☐	☐	Heart Surgery/Artificial Heart Valve/Angioplasty
☐	☐	False Teeth or Retainers
☐	☐	Hearing Aid
☐	☐	Bravo/Endo Capsule or Pillcam
☐	☐	Body Piercing and/or Tattoos
☐	☐	Medication Patch (e.g., Nicotine, Estrogen)
☐	☐	Allergy to Contrast (e.g., Iodine, Gadolinium)
☐	☐	Tissue Expander (e.g., Breast)
☐	☐	Any type of Prosthesis (e.g., Eye, Penile)

The following items may become damaged or cause injury in a strong magnetic field and

MUST NOT BE TAKEN INTO THE SCAN ROOM

WATCH • SAFETY PINS • HAIR PINS • BARRETTE • KEYS • COINS • POCKET KNIFE • WALLET/CREDIT CARDS

_____ _____ _____ _____

Signature of Patient, Parent or Guardian Date Signature of Reviewing Professional Date

In the event of an emergency, your exam time may be delayed. Please bring this form with you to your examination.