

MRI Patient Safety Questionnaire

No wonder people love



Patient Name: _____ Date: _____ Male Female

Requesting Physician: _____ Phone: _____ Work related exam? Yes No

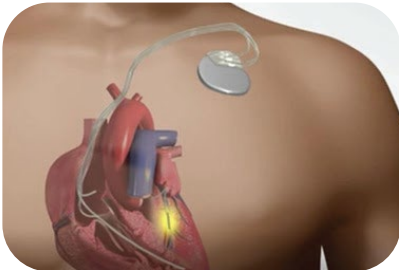
Height: _____ Weight: _____ Birthdate: _____

Any Prior Surgery? Yes No If yes, please name surgery(s) below:

Please remember to remove all metal from your body objects before entering the MRI.

Are any of the items below on or in your body?

Please circle below if "Yes"



Heart/pacemaker | Corazón/marcapasos



Phone, Watch, Key, Credit Card, Knife?



Hearing Aid | Audífono Cochlear Implant



Prosthetic Limb
Extremidad Protésica



Hair Pins | Horquilla



Brain Implant



Bionic Eye Implant
Ojo Biónico



Bullet Ammunition BB | Munición



Metal/dentures In Your Mouth?



Shrapnel In Body? | Metralla En El Cuerpo

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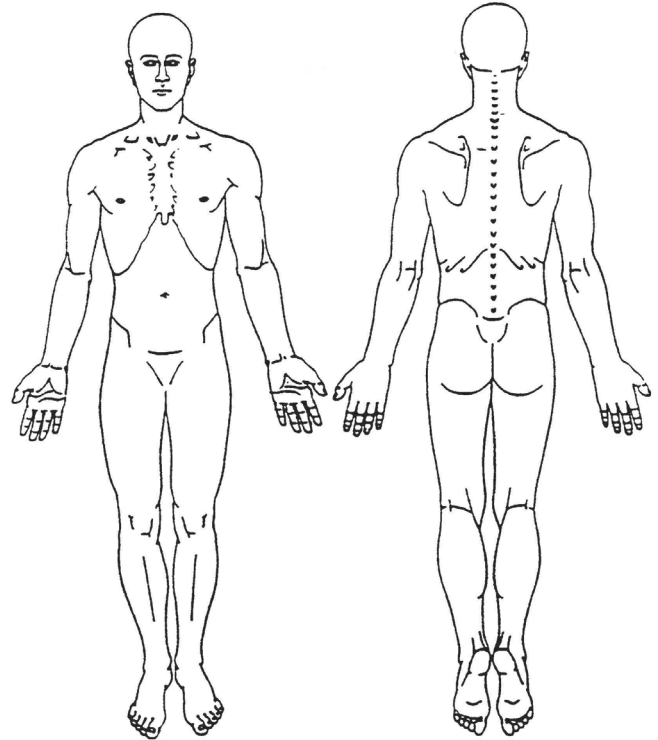


Patient Name: _____

Any other metal in your body not previously described? Yes No

If yes, please state below:

What is your chief complaint or symptom, symptom or injury?



Please Circle scanning area of pain related to this exam?

What is your chief complaint or symptom, symptom or injury?

Yes No

Do you have Allergies? If so, what are you allergic to?

Yes No

Do you have a history of Tumor, Cancer or Lymphoma? If yes, please state

Yes No

Any trauma or physical injury being to the area being scanned?

Yes No

[Women only] Are you now, or could you be pregnant or breastfeeding?

Yes No

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

Patient Signature: _____

Date: _____

Guardian Signature: _____

Date: _____

IIC Medical Staff's section (Completed by IIC's MRI Technologist)

MRI technologist notes: _____

Contrast: Yes No Omniscan Volume: _____ ml Power Injector CC/Sec _____