MRI SAFETY CHECKLIST

HAVE YOU HAD ANY SURGICAL PROCEDURES IN THE PAST 6 WEEKS		☐ YES	☐ NO
DO YOU HAVE A CARDIAC (HEART) PACEMAKER OR WIRES		☐ YES	☐ NO
DO YOU HAVE AN INTERNAL CARDIAC (HEART) DEFIBRILLATOR		☐ YES	☐ NO
DO YOU HAVE AN ARTIFICIAL HEART VALVE		☐ YES	☐ NO
DO YOU HAVE AN ANEURYSM CLIP OR METAL CLIP IN YOUR BODY OR HEART		☐ YES	☐ NO
DO YOU HAVE AN IMPLANTED NEUROSTIMULATOR (TENS) UNIT		☐ YES	☐ NO
DO YOU HAVE ANY TYPE OF BIO/BONE GROWTH/DEEP BRAIN STIMULATOR		☐ YES	☐ NO
DO YOU HAVE ANY INTRAVASCULAR STENTS/FILTERS/COILS		☐ YES	☐ NO
DO YOU HAVE ANY ORTHOPEDIC IMPLANTS, IE. PINS/PLATES/SCREWS/WIRES		☐ YES	☐ NO
DO YOU HAVE ANY ARTIFICIAL OR PROSTHETIC LIMBS		☐ YES	☐ NO
DO YOU HAVE ANY ORBITAL OR EYE PROSTHESIS		☐ YES	☐ NO
DO YOU HAVE ANY EAR PROSTHESIS OR COCHLEAR IMPLANTS		☐ YES	☐ NO
HAVE YOU EVER HAD EAR SURGERY		☐ YES	☐ NO
HAVE YOU EVER HAD AN INJURY TO THE HEAD OR EYES BY METAL		☐ YES	☐ NO
DO YOU HAVE ANY VASCULAR ACCESS PORTS		☐ YES	☐ NO
DO YOU HAVE ANY PERMANENT MAKEUP		☐ YES	☐ NO
DO YOU HAVE ANY BODY PIERCINGS		☐ YES	☐ NO
DO YOU WEAR A HEARING AID		☐ YES	☐ NO
HAVE YOU SWALLOWED A GASTRIC CAPSULE CAMERA IN THE PAST WEEK		☐ YES	☐ NO
ARE YOU CURRENTLY WEARING A MEDICATION PATCH		☐ YES	☐ NO
ARE YOU CURRENTLY WEARING AN INSULIN OR PAIN MEDICATION PUMP		☐ YES	☐ NO
DO YOU CURRENTLY HAVE A TISSUE EXPANDER IMPLANT		☐ YES	☐ NO
FEMALES ONLY	IS THERE A POSSIBILITY YOU COULD BE PREGNANT	☐ YES	☐ NO
FEMALES ONLY	ARE YOU CURRENTLY BREASTFEEDING	☐ YES	☐ NO
FEMALES ONLY	DO YOU HAVE AN INFLATABLE BREAST IMPLANT	☐ YES	☐ NO
MALES ONLY	DO YOU HAVE A PENILE PROSTHESIS	☐ YES	☐ NO

The above information is correct to the best of my knowledge.

Patient Signature ____