**MAGNETIC RESONANCE IMAGING (MRI) SUBJECT SCREENING QUESTIONNAIRE**

**INSTRUCTIONS:** Please respond to items 1-22 below. This information will allow us to determine your eligibility for an MRI scan. Each box should be marked individually—please do not simply draw a line down a column.

1. Do you have a pacemaker, AICD, internal pacing wires, EKG leads or Holter monitor?
2. Do you have an implanted stimulator (including bone growth stimulator, spinal stimulator or cochlear or other ear implant) or medication infusion pump?

STOP "YES" response to either question above requires discussion with Radiology technologist or physician before proceeding.

3. Have you had brain surgery or do you have metallic clips (aneurysm clips) in your head?
4. Have you ever had eye surgery or implants?
5. Have you ever worked around a metal lathe, had metal shavings or fragments in your eye(s), or had a shrapnel (war or gunshot) injury anywhere in your body?
6. Have any devices (e.g., stent, filter, coil or vascular port/catheter) been placed in your blood vessels?
7. Do you have an implanted tissue expander?
8. Do you have a replaced heart valve, other prosthesis or any other surgical implant?
9. List any other type of metal in or on your body: ____________________________
10. Do you have a history of rectal surgery or severe hemorrhoids? (For patients with pelvic or prostate scans)
11. Do you have any tattoos, permanent make-up, or piercings?
12. Do you wear hearing aid(s), either in the ear canal or on the surface? (MUST BE REMOVED before entering room)
13. Do you wear a transdermal medication patch (e.g., Nitroglycerin, Nicotine, etc.)?
14. Do you have kidney/renal disease, liver disease, or diabetes?
15. Do you have any allergies? If so, specify: ____________________________
16. Are you claustrophobic (afraid of enclosed or tight spaces)?
17. Are you wearing a RFID or Radiofrequency ID device (commonly a wristband on an inpatient)?
18. If female, are you (or could you be) pregnant or are you breastfeeding?
19. For gadolinium contrast ("dye") exams, please confirm you have had an opportunity to read the medication guidelines (on the back or on a second page): ☐ ☐
20. Subject age: ________ years
21. Approximate subject weight: ________ (pounds) and height: ________ (feet-inches)
22. Print & sign your name, and indicate date, time & relation to subject

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**CONTRAST SCREENING (FOR GADOLINIUM PATIENTS)**

- **Screening (q 14, 15, 18) and Lab Results**
  - eGFR
  - Cr
  - Non AA, AA
  - RNI

- **Outcome:**
  - Routine Injection
  - Contrast Reaction
  - Extravasation
  - Other Event

- **Injection Personnel**
  - Printed Name: ____________________________
  - Signature: ____________________________
  - Date / Time: ________ / ________ pm

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**WARNING: THE MRI MAGNET IS ALWAYS ON!**

Do not enter the MRI scanner room or the MRI environment if you have any question or concern regarding an implant, device or object. Consult the MRI technologist or radiologist BEFORE entering an MRI room.

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**PRINTED NAME**

**DATE** / **TIME**

**NAME OF INDIVIDUAL ASSISTING**

**DATE** / **TIME**

**SIGNATURE**

**RN** ☐, **MD** ☐, **Other** ☐

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**GADOLINIUM INJECTION RECORD**

**CONTRAST AGENT**

**SITE**

**VOLUME** mL

**RATE** mL/s

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**CHECK** if drawn as Point-of-Care Test in Radiology

**DRAWN** / **REVIEWED** / **RESULTS**

**OUTCOME:**

- Routine Injection
- Contrast Reaction
- Extravasation
- Other Event

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**PRINTED NAME**

**SIGNATURE**

**DATE** / **TIME**

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**Circa:** 2018/06/12 (Form MR-1679)