McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Place Patient Identification/ADT Label Here:

MRI Screening Form

Patient Name: _____ MRN: _____
last name, first name

Date of Birth: _____ Gender Identity: _____ Sex at Birth: _____

Guardian Name & Relationship: _____ Ordering Provider: _____

PT/Guardian Tel: _____ Provider Tel: _____

MRI Screening Questions:

Have you ever had surgery of any kind? ☐ If yes, please provide details (date, facility, body part):

_____

Have you had an injury where metal might have been left in your body? ☐

Select all that apply:
☐ BB ☐ Needles ☐ Welding Injury ☐ None
☐ Bullet ☐ Shrapnel ☐ Metallic Foreign Body

Other, please describe: _____

Have you been treated for metal in the eye? ☐

Do you have anything implanted in your body (medical or non-medical)? Check all that apply:

☐ Shunt
☐ Aneurysm Clip or Clips
☐ Coil
☐ Eyelid Spring
☐ Cochlear Implant
☐ IUD
☐ Hormone Implant
☐ Tissue Expander
☐ Pacemaker
☐ Defibrillator
☐ Internal Electrodes or Wires
☐ Valve Replacement
☐ Stent
☐ Cardiac Loop Recorder
☐ Filter
☐ Coil
☐ Electronic Device
☐ Electronic Stimulator
☐ Medication Pump
☐ Endoscopy/Colonoscopy Clips
☐ Non Medical Implant
☐ Other: _____

Is anything attached to your body other than clothing (must be removed prior to MRI)? ☐

Select all that apply:
☐ Dentures ☐ Medicine Patch ☐ Wig ☐ Piercing ☐ Jewelry
☐ Hearing Aid ☐ Magnetic Eyelashes ☐ Other ☐ None

Department Personnel Only:

_____ **Date:** _____ **Time:** _____
Reviewed by: Level I Personnel/Technologist Name

_____ **Date:** _____ **Time:** _____
Reviewed by: Level II Personnel/Technologist Name

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Place Patient Identification/ADT Label Here:

MRI Screening Form- Continued

Patient Name: _____ MRN: _____

Have you ever had difficulty while getting an IV OR do you have a port-a-cath that will need to be accessed? ☐

If yes, please select any you've experienced or all that apply:

☐ Dizziness ☐ Fainting

☐ Difficulty finding veins ☐ Port-A-Cath ☐ PICC line ☐ N/A

Have you ever had a reaction to contrast material used for an MRI (gadolinium)? ☐

Have you ever had trouble tolerating an MRI due to claustrophobia? ☐

If yes, do you need to be pre-medicated? ☐

Do you have known kidney disease or acute kidney injury? ☐ Unsure

Do any of the following apply?

☐ Diabetes ☐ Being treated for cancer in last 30 days

☐ Hypertension treated with medication ☐ Multiple Myeloma ☐ Feraheme (R) (ferumoxytol) injection within the past 90 days

☐ N/A

For females of childbearing age (10-65):

Are you currently breast feeding? ☐

Are you pregnant or is there a chance you could be pregnant? ☐ If unsure, confirm with patient ☐

_____ **Date:** _____ **Time:** _____

Form completed by (Printed Name and Relationship)

_____ **Date:** _____ **Time:** _____

Patient/Guardian Signature

_____ **Date:** _____ **Time:** _____

Reviewed by: Level I Personnel/Technologist Signature

_____ **Date:** _____ **Time:** _____

Reviewed by: Level II Personnel/Technologist Name