

MRI METAL SAFETY SHEET



WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. **The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aneurysm clip(s) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cardiac pacemaker |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted cardioverter defibrillator (ICD) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Electronic implant or device |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Magnetically-activated implant or device |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurostimulation system |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Spinal cord stimulator |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Internal electrodes or wires |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone growth/bone fusion stimulator |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cochlear, otologic, or other ear implant |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Insulin or other infusion pump |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted drug infusion device |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any type of prosthesis (eye, penile, etc.) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart valve prosthesis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eyelid spring or wire |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial or prosthetic limb |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metallic stent, filter, or coil |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shunt (spinal or intraventricular) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vascular access port and/or catheter |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation seeds or implants |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swan-Ganz or thermodilution catheter |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you greater than 60 years of age |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Acute renal injury |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Acute/Chronic severe renal insufficiency |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | History of Liver Disease/Transplant/
pending Liver Transplant |

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | History of hypertension |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | History of diabetes |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Medication patch (Nicotine, Nitroglycerine) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any metallic fragment or foreign body
(Gunshot, BB, Bullet, Shrapnel Injuries) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Previous eye injury involving a metal object
(Metal Slivers, Shavings, Foreign Body) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wire mesh implant |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tissue expander (e.g., breast) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgical staples, clips, or metallic sutures |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint replacement (hip, knee, etc.) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone/joint pin, screw, nail, wire, plate, etc. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | IUD, diaphragm, or pessary |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dentures or partial plates |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tattoo or permanent makeup |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Body piercing jewelry |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing aid
(Remove before entering MR system room) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other implant _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breathing problem or motion disorder |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Claustrophobia |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any form of Anemia |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you pregnant |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you breastfeeding |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any disease that affects red blood cells |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any form of cancer |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Sclerosis |

Recent Creatinine _____ Date: _____ and/or GFR _____ Date: _____

IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any questions or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date: ____/____/____
Signature

Form Completed By: Patient Relative Nurse _____
Print Name Relationship to Patient

Form Information Reviewed By: _____
Print Name Signature



- MRI Technologist Nurse Radiologist Other