UCLA Health System

MRN:
Patient Name:

(Patient Label)

MRI SAFETY SCREENING QUESTIONNAIRE (INPATIENTS)

MRI – SMH extension 92886 / FAX 94043 **MRI – RRUMC extension 78745 / FAX 73782**

Height: _____ Weight: _____ Floor/Unit: _____ Bed: _____ Physician: _____

The following items may be harmful to you during your MR scan or may interfere with the MR examination. Please provide a "yes" or "no" answer for every item.

YES	NO	
☐	☐	Cardiac pacemaker or implanted cardiac defibrillator/ICD
☐	☐	Internal electrodes or wires (pacing wires, DBS or VNS wires)
☐	☐	Artificial heart valve, coil, filter and/or stent (Gianturco coil, IVC filter)
☐	☐	Aneurysm clip(s)
☐	☐	Neurostimulator and/or Biostimulator
☐	☐	Implanted drug pump (insulin, chemotherapy, pain medicine)
☐	☐	IV access port (Port-a-Cath, Broviac, Hickman, PICC line, Swan-Gantz)
☐	☐	Implanted post surgical hardware (pins, rods, screws, plates, wires)
☐	☐	Artificial joint and /or limb
☐	☐	Artificial eye and/or eyelid spring
☐	☐	Eye injury from a metal object (metal shavings, metal slivers)
☐	☐	Ear (Cochlear) implant, middle ear implant
☐	☐	Hearing aid(s)
☐	☐	False teeth/dentures, metallic removable dental work, braces, retainers
☐	☐	Any type of implant held in place by a magnet
☐	☐	Injured by a metal object (shrapnel, bullet, BB) and required medical attention
☐	☐	Medication patch (nitroglycerine, nicotine, estrogen)
☐	☐	Shunt
☐	☐	Spinal fixation device, spinal fusion and/or halo vest
☐	☐	Surgical clips, staples or surgical mesh
☐	☐	Tissue expander (breast)
☐	☐	Penile implant
☐	☐	Pessary, IUD, Diaphragm
☐	☐	Radiation seeds (cancer treatment)
☐	☐	Body piercing, tattoo or tattooed makeup
☐	☐	Wig, hair implants

Nursing Staff – YES answer to any of the above item/implant questions, please call MRI.

Do you have a history of:

YES	NO		YES	NO	
☐	☐	Kidney disease	☐	☐	Congestive heart failure
☐	☐	Diabetes	☐	☐	Liver disease
☐	☐	High blood pressure	☐	☐	Nephrogenic Systemic Fibrosis/NSF

Are you on dialysis? ☐ YES ☐ NO If YES, Hemodialysis or Peridialysis? (circle one)

Do you use non-steroidal anti-inflammatory drugs on a daily basis? ☐ YES ☐ NO

Nursing Staff – YES answer to any of the above patient history questions please provide:

Creatinine Value: _____ GFR Value: _____ Date Acquired: _____

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YES	NO	
☐	☐	Do you have a history of asthma, or allergic respiratory disorders?
☐	☐	Do you have a drug allergy or latex allergy? Type_____
☐	☐	Are you pregnant or possibly pregnant? (If YES, give written informed consent)
☐	☐	Are you breast-feeding? (If YES, please request MRI prep instructions)
☐	☐	Are you claustrophobic? (If YES, please request sedation)
☐	☐	Are you in pain or discomfort? (If YES, please request pain medication)
☐	☐	Can you lay flat for an extended period?

The following section to be completed by the Patient's Nurse, Care Partner, or Physician:

YES	NO	
☐	☐	Is the patient cooperative, coherent, and responsive?
☐	☐	Does the patient need continuous nursing care? Is a transport nurse needed?
☐	☐	Is the patient on a cardiac monitor or a ventilator?
☐	☐	Does the patient require oxygen for transport?
☐	☐	Does the patient have peripheral IV access? (min. 20 g for MRA procedures).
☐	☐	Is this patient in Isolation? If YES, what type?: _____
☐	☐	Does the patient have a history of a MRI contrast allergy? (If YES, pre-medication is required)
☐	☐	Has the patient had surgery to the site to be examined? If YES, when, and what surgery? _____.
☐	☐	Has the patient had previous MRI, CT, or X rays to the site to be examined? If so, what, where, and when: _____.

I attest the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

_____	_____	_____
Patient/Parent/Guardian/Other Signature	Date	Time
_____	_____	_____
MR Technologist/MR Assistant/Other Signature	Date	Time

IMPORTANT! Prior to transport to MRI all metal must be removed! No jewelry, watches, dentures, eyeglasses, hearing aids! No valuables!

FOR MRI STAFF USE ONLY

CONTRAST ORDER/SIGNATURE	**To Be Filed in the Medical Record**
Contrast Type:_____ Injection Rate:_____ Injection Amount:_____	
Creatinine/GFR screening waived by: _____	
MR Technologist/RN/MD Signature: _____ Date_____ Time_____	
Radiologist Signature: _____Date_____ Time_____	