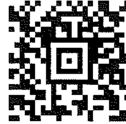
M2326
Rev. 8/15

DukeHealth

PATIENT MRI SAFETY SCREENING



Place Patient Label Here

☐ Duke University Hospital ☐ Duke Raleigh Hospital

☐ Duke Regional Hospital ☐ Davis Ambulatory Surgery Center

☐ Other ______________________________ (Please specify)

You have been scheduled for an MRI exam. The MRI scanner uses extremely strong magnetic fields that can produce heating, movement or electric currents in **ANY metal** in or on your body. **WARNING:** This can be hazardous to you if you have certain metal objects in or on you. Please complete this form accurately and carefully.

Section 1: Please mark **ALL** that may apply: (If patient is unable to give accurate answers please see section 4)

Have you had **surgeries** to the: ☐ BRAIN ☐ HEART ☐ SPINE

Have you had an **injury to the eye** involving a metal object or fragment (grinding or welding)? ☐ Yes ☐ No

Have you ever been **injured by a metallic object or foreign body** (e.g. BB, bullet, shrapnel)? ☐ Yes ☐ No

Please list ALL Surgeries: ____

____

For WOMEN: Date of last menstrual period? _____/____/____

Section 2: Please mark **ALL** that apply: (If patient is unable to give accurate answers please see section 4)

☐ Yes	☐ No	Pacemaker / defibrillator (ICD)	☐ Yes	☐ No	Heart valve prosthesis
☐ Yes	☐ No	Aneurysm clip(s) / aneurysm repair	☐ Yes	☐ No	Prosthetic limb
☐ Yes	☐ No	Breast tissue expander	☐ Yes	☐ No	Vascular stent, filter, coil
☐ Yes	☐ No	Drug infusion device or pump	☐ Yes	☐ No	Programmable shunt
☐ Yes	☐ No	Vagus Nerve Stimulator (VNS)	☐ Yes	☐ No	Prosthesis (penile, eye etc.)
☐ Yes	☐ No	Stimulator/implanted electrical device	☐ Yes	☐ No	Cochlear, ear, or inner ear surgery
☐ Yes	☐ No	Internal electrodes or wires	☐ Yes	☐ No	Eyelid implant, eye surgery
☐ Yes	☐ No	Tracheostomy	☐ Yes	☐ No	Body jewelry, piercings and/or tattoo(s)
☐ Yes	☐ No	Medication patch	☐ Yes	☐ No	Hx of Gunshot or Shrapnel wound
☐ Yes	☐ No	Epidural/Swan-Ganz catheter	☐ Yes	☐ No	Metal rods, screws, pins etc.
☐ Yes	☐ No	IUD or pessary	☐ Yes	☐ No	Joint replacement (knee, hip, etc.)
☐ Yes	☐ No	Recent endoscopy	☐ Yes	☐ No	Dentures / partial plates
☐ Yes	☐ No	Have you had a prior MRI?	☐ Yes	☐ No	Hearing aid (remove before entering room)
If yes, where? ______________			☐ Yes	☐ No	Claustrophobia

Section 3: (Must be completed by patient or person reviewing form with patient)

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

Form completed by (Circle One): Patient / Relative / RN / MD Signature:________________________

Print Name:______________________________________ Date:____/____/____ Time:____:____

Section 4: (Hospital Staff Use Only) **Attention Clinicians:** If the patient is unable to <u>**accurately**</u> complete the screening form, either written or verbally, the following must be performed before it can be determined if it is safe to perform an MRI:

1. Review patient's EMR for prior surgeries or procedures and mark appropriate area(s) in Sections 1 & 2.
2 Ensure imaging of the skull and/or orbits, neck, chest, abdomen and pelvis to exclude metallic foreign objects (if recently obtained plain films, CT, or MR studies of such areas are not already available). Such imaging studies are to be ordered by the ordering clinician/service.
3 Perform a physical exam on patient to evaluate for any unexplained scars or surgeries not documented in the patient's EMR. Orders for radiograph must be placed for any additional areas of concern.

I have performed all steps in Section 4 :______________________________ ___/___/___ ____:____

Clinician Signature **Date** **Time**

Section 5: (MRI Staff Use Only)

Reviewed by: ____________________________/______________________________ ____/____/____ ____/____

MRI Technologist Signature **MRI Technologist Printed Name** **Date** **Time**