DukeHealth
MRI SAFETY SCREENING

☐ Duke University Hospital  ☐ Duke Raleigh Hospital  ☐ Duke Regional Hospital  ☐ Davis Ambulatory Surgery Center
☐ Other __________________________ (Please specify)

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:

Section 2: Please mark ALL that may apply: (If patient is unable to give accurate answers please see section 4)
☐ Yes  ☐ No Pacemaker / defibrillator (ICD)
☐ Yes  ☐ No Aneurysm clip(s) / aneurysm repair
☐ Yes  ☐ No Breast tissue expander
☐ Yes  ☐ No Drug infusion device or pump
☐ Yes  ☐ No Vagus Nerve Stimulator (VNS)
☐ Yes  ☐ No Stimulator/implanted electrical device
☐ Yes  ☐ No Internal electrodes or wires
☐ Yes  ☐ No Tracheostomy
☐ Yes  ☐ No Medication patch
☐ Yes  ☐ No Epidural/Swan-Ganz catheter
☐ Yes  ☐ No IUD or pessary
☐ Yes  ☐ No Recent endoscopy
☐ Yes  ☐ No Have you had a prior MRI?
If yes, where? __________________________

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: ☐ Patient  ☐ Relative  ☐ RN  ☐ MD  ☐ Technologist
Print Name: __________________________ Date: _____/_____/______ Time: __:__

Section 4: (Hospital Staff Use Only) Attention Clinicians: If the patient is unable to accurately 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 identify 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 - Must be completed by staff reviewing form)

___________________________ / __________________________
Printed Name  Signature  (Circle One): MD/RN/CRNA/Technologist
___________________________ / __________________________ Date: _____/_____/______ Time: __:__
Section 6 Patient History: the information below must be completed by patient or person reviewing form with patient.

1. Reason for exam (patient's explanation):

2. How long has this been a problem?

3. Any additional Information?

Section 7 Contrast Assessment: For patients who may receive MRI CONTRAST or "DYE" (GADOLINIUM), the below must be completed by patient or person reviewing form with patient. Please circle YES or NO

1. Do you have a history of kidney disease, including:
   - Dialysis  □ Yes □ No
   - Kidney transplant  □ Yes □ No
   - Acute or chronic kidney failure  □ Yes □ No

2. Have you had a reaction to intravenous contrast ("dye") used in MRI?
   □ Yes □ No

3. FOR WOMEN: Are you pregnant or could you be pregnant?
   □ Yes □ No

I have been provided a Medication Guide that explains the risks associated with Gadolinium Based Contrast Agents (GBCA), verbalizes understanding, and denies questions.

Patient or Designee Print Name:

Patient or Designee Signature: ____________________________  Date: __/__/____  Time: ____:

For MRI Staff Use Only

If the patient answers YES to Question 1 above: Enter eGFR in the box to the right*

If the patient answers YES to Question 2 enter pre-medication information below.

Medication: ____________________________  Dose: ________  Time Taken/Given: 13hr:____  7hr:____  1hr:____

* eGFR ________ ml/min/1.73m²

Date __/__/____

Section 8 Safety Check: "TIME OUT" to be performed by the level 2 MR technologist PRIOR to permitting entry into Zone IV.

Correct Patient using TWO Identifiers per DUHS Policy (e.g. patient name and DOB)?  □ Yes □ No

Correct Body Part and Laterality?  □ Yes □ No

Correct Procedure and Protocol?  □ Yes □ No

MRI Screening Complete?  □ Yes □ No

All equipment cleared for safe entry and use in Zone IV?  □ Yes □ No

All patients and individuals cleared for safe entry into Zone IV?  □ Yes □ No

*MR Technologist signing acknowledges that all criteria have been met as per the Duke Health MRI Safety Pause Policy.

____________________  /  ______________________  /  ____:

MRI Technologist Signature  MRI Technologist Printed Name  Date  Time

Comments

Exam Protocol: ____________________________  Protocoling Radiologist: ____________________________

Contrast Agent (Circle One): MultiHance  Eovist  ProHance  Feraheine  Gadavist

Dose: ________ mL