Location:

Patient:

Date of Service:

Procedure:

MR Room (Metal) Questionnaire

TO OUR PATIENTS AND ACCOMPANYING FAMILY MEMBERS...
The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body. Some metal objects can interfere with your scan or may even be dangerous, so PLEASE answer the following questions carefully. If you have a question regarding anything on this form, PLEASE DO NOT HESITATE TO ASK US!

Yes No Have you ever had an operation or surgery of any kind? If so, please list them all with dates.

Yes No Are you claustrophobic?

Yes No Have you ever been a machinist, welder, or metalworker?

Yes No Have you ever been hit in the face or eye with a piece of metal (including metal shavings, slivers, bullets or BBs)?

Yes No Have you ever had a piece of metal removed from your eye?

Yes No Are you pregnant, possibly pregnant, or breast feeding?

Do you have any of these items in your body?

Yes No Pacemaker, wires, or defibrillator
Yes No Body piercing
Yes No Brain aneurysm clip
Yes No Ear implant
Yes No Eye implant
Yes No Electrical stimulator for nerves or bone
Yes No Bullets, BBs, or pellets
Yes No Metal shrapnel or fragments
Yes No Magnetic implant anywhere
Yes No Infusion pump
Yes No Coil, filter, or wire in blood vessel
Yes No Artificial limb or joint
Yes No Tattoos
Yes No Implanted catheter or tube
Yes No Artificial heart valve
Yes No Penile prosthesis
Yes No Shunt
Yes No Ortho devices (plates/screws/pins/rods/wires)
Yes No Surgical clips, staples, wires, mesh, or stitches
Yes No Diaphragm or intrauterine device

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

Signature (Parent or Guardian)

Date Signed: