

# MRI Fox Valley Orthopaedic —MR Screening Level 2

Name \_\_\_\_\_  
 (Please Print) Last First

**IMPORTANT INSTRUCTIONS**

Before entering the MR scan room, you must remove ALL metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, clothing with metallic threads, and steel toed footwear.

Please check yes or no in the following list and circle any device you have:

- YES  NO Aneurysm clip(s) in the brain
- YES  NO Cardiac Pacemaker or Implanted cardiac defibrillator (ICD)
- YES  NO Brain Surgery [staple(s), clip(s), intraventricular shunt or valve]
- YES  NO Heart Surgery [Coronary stent(s), heart valve(s), occluders, cardiac-catheter(s)]
- YES  NO Middle/Inner Ear Surgery [Cochlear implant, stapes, ear implant or prosthesis]
- YES  NO Eye Surgery (lens implant, eye prosthetic, eye-lid spring, or glaucoma shunt)
- YES  NO Any other prosthesis or implant [breast, breast tissue expander, penile, artificial limb]
- YES  NO Radiation seeds or implants
- YES  NO Surgical staple(s), clip(s), wire mesh or metallic suture(s). Location: \_\_\_\_\_
- YES  NO Joint replacement, bone pin(s), screw(s), nail(s), wire(s), plate(s) list: \_\_\_\_\_
- YES  NO Shunts or shunt valves [spinal or intraventricular]
- YES  NO Catheters or vascular access port Location: \_\_\_\_\_
- YES  NO Stents, filter(s), coil(s), graft(s), or clamp(s) Location: \_\_\_\_\_
- YES  NO Bone growth/fusion stimulator. Neurostimulator, spinal cord stimulator
- YES  NO Internal or external electrode(s) or wire(s) [pacer wires, tens unit]
- YES  NO Infusion drug, pain, or insulin pump [implanted or external}. Location: \_\_\_\_\_
- YES  NO Any device with magnets [eye, dental, stoma, valve] Location: \_\_\_\_\_
- YES  NO History of injury involving a metallic fragment(s) [slivers, shrapnel, bullet, pellets]  
 Location: \_\_\_\_\_
- YES  NO Have you *ever* had an injury to your eye(s) involving metal? Date: \_\_\_\_\_
- YES  NO Have you *ever* cut or ground metal with a high-speed tool? Last used: \_\_\_\_\_
- YES  NO Medication patches
- YES  NO Dentures or partial plates
- YES  NO Any Tattoo(s), permanent makeup, hair extensions, or hairpieces.
- YES  NO Body piercing jewelry [ear(s), navel, tongue, etc.] other: \_\_\_\_\_
- YES  NO Hearing aid [Remove before entering MR room]

Female Patients:

- YES  NO Are you pregnant or suspect that you could be pregnant?  
 Date of last menses: \_\_\_\_\_ (required)
- YES  NO Do you have an IUD or diaphragm currently in place?
- YES  NO Are you currently breast-feeding?

I attest that the above information is correct to the best of my knowledge. I have informed the MRI technologist of my surgical history before entering the MRI scan room. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form.

Patient/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_

**You do not need to complete the back side of this form-intended for MR staff.**