



# RADIOLOGY ASSOCIATES OF WAUSAU, S.C. OPEN MRI OF WAUSAU



## MAGNETIC RESONANCE IMAGING (MRI) SAFETY RECORD

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Describe any symptoms you are having: \_\_\_\_\_

Have you had surgery in the area being scanned?  YES  NO

Facility: \_\_\_\_\_ Date: \_\_\_\_\_

Have you had a previous MRI of this area?  YES  NO

Facility: \_\_\_\_\_ Date: \_\_\_\_\_

Were there any x-rays taken for this problem?  YES  NO

Trauma/Injury to area being scanned?  YES  NO

Have you ever been diagnosed with any of the following?

Kidney Disease/  
Decreased Function?  YES  NO

On Dialysis?  YES  NO

High Blood Pressure?  YES  NO

Diabetes?  YES  NO

Insulin Dependent?  YES  NO

Cancer?  YES  NO

Type: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

- PLEASE COMPLETE THE FOLLOWING CHECKLIST**  
(Please hold any questions for the MRI Technologist)
- | YES                      | NO                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Can you lie on your back for at least 45 minutes?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you claustrophobic or afraid of small places?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been a machinist, welder, or metal-worker?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hit in the face or eye with a piece of metal?<br>(Including metal shavings, slivers, bullets or BB's) |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant, possibly pregnant, or breast feeding?  |

GFR: \_\_\_\_\_

LMP: \_\_\_\_\_

- DO YOU HAVE ANY OF THESE ITEMS IN OR ON YOUR BODY?** (Explain YES answers)
- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker, Pacer Wires, Defibrillator (ICD)                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain Surgery/Brain Aneurysm Clip                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear Implant/Inner Ear Surgery/Cochlear Implant, Etc.                |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Implant/Eye Surgery/Eyelid Spring or Wire                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Electrical Stimulator/Tens Unit/Electronic Implant/Device           |
| <input type="checkbox"/> | <input type="checkbox"/> | Bullets/BB's/Pellets/Shrapnel/Fragments – If yes, where:            |
| <input type="checkbox"/> | <input type="checkbox"/> | Implanted Medication Pump/Infusion Pump/Device                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Stimulator System: Neuro, Spinal, Bladder, Bone                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Magnetically-Activated Implant/Device                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Shunt (Spinal or Intraventricular)                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Limb/Joint/Prosthesis (e.g., Plates, Screws, Pins, Rods) |
| <input type="checkbox"/> | <input type="checkbox"/> | Coil/ Filter/Stent in Blood Vessel                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery/Artificial Heart Valve/Angioplasty                    |
| <input type="checkbox"/> | <input type="checkbox"/> | False Teeth or Retainers  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Aid   |
| <input type="checkbox"/> | <input type="checkbox"/> | Bravo/Endo Capsule or Pillcam                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Body Piercing and/or Tattoos  |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication Patch (e.g., Nicotine, Estrogen)                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergy to Contrast (e.g., Iodine, Gadolinium)                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Tissue Expander (e.g., Breast)                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of Prosthesis (e.g., Eye, Penile)                          |

**The following items may become damaged or cause injury in a strong magnetic field and  
MUST NOT BE TAKEN INTO THE SCAN ROOM**

**WATCH • SAFETY PINS • HAIR PINS • BARRETTE • KEYS • COINS • POCKET KNIFE • WALLET/CREDIT CARDS**

Signature of Patient, Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_ Signature of Reviewing Professional \_\_\_\_\_ Date \_\_\_\_\_

*In the event of an emergency, your exam time may be delayed. Please bring this form with you to your examination.*