PALMS IMAGING CENTER
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MRI Screening Form

YES	NO	
☐	☐	Ever had Metal Removed from Your Eye(s)
☐	☐	Ever Worked with Metal (i.e. Welding, Grinding, etc.)
☐	☐	Cardiac Pacemaker
☐	☐	Aneurysm Clip(s)
☐	☐	Implanted Cardiac Defibrillator
☐	☐	Neurostimulator
☐	☐	Breast Tissue Expander
☐	☐	Any Type of Biostimulator, Type: ______________________
☐	☐	Pacing Wires, Cochlear Implant, Other: ______________________
☐	☐	Implanted Insulin Pump
☐	☐	Any Type of Electronic, Mechanical, or Magnetic Implants Type: ______________________
☐	☐	Implanted Drug Infusion Pump
☐	☐	Any Type of Foreign Body, Shrapnel or Bullet
☐	☐	Any Type, of Implant, Held by Magnet
☐	☐	Any Implanted Orthopedic Items (i.e. Pins, Screws, Plates)
☐	☐	Artificial Limb or Joint
☐	☐	Any Type of Surgical Clip or Staple(s)
☐	☐	Halo Vest or Metallic Cervical Fixation Device
☐	☐	Are You Pregnant
☐	☐	Swan-Ganz Catheter
☐	☐	Heart Valve
☐	☐	Any Type of Ear Implant
☐	☐	Penile Prosthesis
☐	☐	Dentures
☐	☐	Diaphragm
☐	☐	IUD
☐	☐	Pessary
☐	☐	Wire Mesh
☐	☐	Attached Weights of any Kind (i.e. Ankle, Body)
☐	☐	Body Piercing
☐	☐	Diabetes
☐	☐	Tattoos of any Type (a Small Percentage of Patients with Tattoos Experience Transient Skin Irritation in Association with MRI)
☐	☐	Kidney Problems (i.e. Renal Failure, Hypertension, one Kidney)

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

Patients Signature: ______________________ Date: __________

RN/RT Signature: ______________________ Date: __________

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Rev 9/19