Barnes-Jewish Hospital BJC HealthCare | Children's Hospital • St. Louis BJC HealthCare | Washington University in St. Louis School of Medicine

Patient Name: _____

Age: _____ DOB: _____

Weight: _____ Height: _____

Date of Exam: _____

PATIENT IDENTIFICATION

MRI SCREENING QUESTIONNAIRE: PATIENT

For your safety, all metallic objects must be removed prior to your MRI exam.
For any implanted devices, please present your implant card for review.

LIST ALL PAST SURGERIES (including orthopedic/joint pins, wires):

Cardiac Pacemaker	☐ Yes	☐ No	Claustrophobic	☐ Yes	☐ No
Implanted Cardiac Defibrillator	☐ Yes	☐ No	Allergy to MRI Contrast Describe:	☐ Yes	☐ No
Pacer Wires	☐ Yes	☐ No	Pregnant Breastfeeding	☐ Yes ☐ Yes	☐ No ☐ No
Artificial Heart Valve	☐ Yes	☐ No	Kidney Disease Dialysis	☐ Yes ☐ Yes	☐ No ☐ No
Cardiac stents	☐ Yes	☐ No	Penile implant Prostate or other radiation seeds	☐ Yes ☐ Yes	☐ No ☐ No
Eyelid Spring or Retinal Tacks	☐ Yes	☐ No	Tissue Expanders (Breast or other) Tracheotomy	☐ Yes ☐ Yes	☐ No ☐ No
Cochlear or Other Ear Implants	☐ Yes	☐ No	Endoscopy Camera and/or Pill Date swallowed:	☐ Yes	☐ No
Tattoos, Tattoo Eye or Lip Liner	☐ Yes	☐ No	Brain Aneurysm Clip Date:	☐ Yes	☐ No
Metal in Eye Describe:	☐ Yes	☐ No	Neurostimulator Spine stimulator	☐ Yes ☐ Yes	☐ No ☐ No
Bullets, BBs, Shrapnel Describe:	☐ Yes	☐ No	Spinal or ventricular Shunt	☐ Yes	☐ No
Any Implanted Drug Pumps Describe:	☐ Yes	☐ No	Any Other Implanted Metal or Device Date: Type:	☐ Yes	☐ No
Diaphragm / IUD Bladder ring	☐ Yes ☐ Yes	☐ No ☐ No	Any Other Coils, Filters, or Stents Describe:	☐ Yes	☐ No

If you responded "Yes" to any of the items below, for your safety, the items MUST be removed.

Hearing Aid	☐ Yes	☐ No	False Teeth or Partial Plate	☐ Yes	☐ No
Medication Patch/Metal dressing	☐ Yes	☐ No	Body Piercing	☐ Yes	☐ No
Artificial Limb	☐ Yes	☐ No	Wig, Hair Implants, Clips or Pins	☐ Yes	☐ No
Artificial limb electronics	☐ Yes	☐ No	Insulin Pump or glucose monitor	☐ Yes	☐ No

COMMENTS:

Form completed by: ☐ Patient ☐ Parent (required if age 17 and under) ☐ Clinician ☐ Other _____

Signature of Person Completing Form	Printed Name of Person Completing Form	Date	Time

MRI: ☐ Approved ☐ Conditional ☐ Not approved ☐ See device screening form for details

MRI Level II Signature	MRI Level II Printed Name	Date	Time

DO NOT WRITE BELOW THIS LINE

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