

Nothing should enter the examination room that can be attracted to a magnet. All persons entering the examination room should review and identify any possible contraindications prior to entering the MRI scan room.

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following. Do you have any of the following?

- | | | |
|-----------|----------|--|
| _____ Yes | _____ No | Have you ever had surgery? If yes, please explain:
_____ |
| _____ Yes | _____ No | Have you ever been hospitalized? |
| _____ Yes | _____ No | Cardiac Pacemaker? |
| _____ Yes | _____ No | Implanted cardiac defibrillator? |
| _____ Yes | _____ No | Internal pacing wires? |
| _____ Yes | _____ No | Clips such as cerebral, carotid, aortic aneurysm or abdominal? |
| _____ Yes | _____ No | IUD or Diaphragm? (Brand name: _____) |
| _____ Yes | _____ No | Intravascular stents, filters, or coils (date of procedure ____/____)? |
| _____ Yes | _____ No | Breast tissue expander or breast biopsy markers: Brand: _____? |
| _____ Yes | _____ No | Neurostimulator/Bone growth or fusion stimulator? |
| _____ Yes | _____ No | Insulin or another drug infusion pump? |
| _____ Yes | _____ No | Any type of prosthesis or artificial limb (eye, penile, leg etc.)? |
| _____ Yes | _____ No | Heart valve prosthesis? |
| _____ Yes | _____ No | Shunt (spinal or intraventricular)? |
| _____ Yes | _____ No | Electrodes (on body, head, or brain)? |
| _____ Yes | _____ No | Cochlear or ocular implants? Any implant held in by magnets? |
| _____ Yes | _____ No | Any metal fragments? |
| _____ Yes | _____ No | Metal removed from your eye? |
| _____ Yes | _____ No | Swan-Ganz catheter? |
| _____ Yes | _____ No | Vascular access port of catheter? |
| _____ Yes | _____ No | Transdermal delivery system (Nitro)? |
| _____ Yes | _____ No | Antibiotic joint spacer? |
| _____ Yes | _____ No | Metal or wire mesh implants? |
| _____ Yes | _____ No | Metal rods or plates in body? |
| _____ Yes | _____ No | Joint replacement? |
| _____ Yes | _____ No | Body piercings? (If yes- must be removed before scan) |
| _____ Yes | _____ No | Hearing aid? (If yes- must be removed before scan) |
| _____ Yes | _____ No | Dentures? |
| _____ Yes | _____ No | Braces, permanent retainer or spacer? |
| _____ Yes | _____ No | Tattooed makeup (eyeliner, lips, etc.)? |

GFR Measurement: _____ Contrast/Dose _____

Have you had an MRI before? _____ If yes, when and where? _____

_____ / _____ / _____
Subject's signature **Date**

Subject's height and weight: _____ / _____ **Subject's birthdate:** _____