

(Office use)

## MRI: SAFETY QUESTIONNAIRE/AUTHORIZATION

**MRI is simple, safe and painless. However, because we use strong magnets during the procedure, metal objects in your body may be hazardous or cause interference. Please provide us with this important information before entering the MRI department.**

Name \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

1. Have you ever been here before? Yes  No  If yes, when: \_\_\_\_\_
2. Have you ever had an MRI? Yes  No  Date and Place of last MRI: \_\_\_\_\_  
List other Imaging related to today's examination with date and location (Cat Scans, Ultrasound, X-Ray): \_\_\_\_\_
3. Please list any oral medications you have taken today (including any medication for anxiety or claustrophobia): \_\_\_\_\_
4. Please list **all** surgical procedures and dates or, check here for **none** .

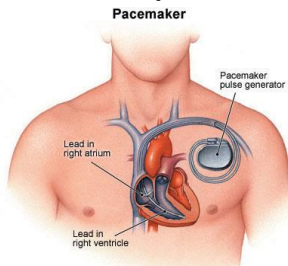
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

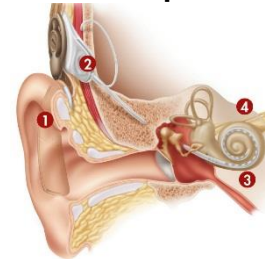
### IF YOU HAVE EITHER OF THE DEVICES BELOW YOU CANNOT HAVE AN MRI.

#### Pacemaker / Defibrillator (ICD)



# STOP

#### Cochlear Implant



### 5. Please check YES or NO in the boxes below if you have any of the following items in your body:

- |   |  |
|---|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> Cardiac pacemaker or pacing wires                      | Yes <input type="checkbox"/> No <input type="checkbox"/> Tissue expander (e.g., breast)                    |
| Yes <input type="checkbox"/> No <input type="checkbox"/> External Cardiac monitor or wiring                     | Yes <input type="checkbox"/> No <input type="checkbox"/> Port  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Implanted cardioverter defibrillator (ICD)             | Yes <input type="checkbox"/> No <input type="checkbox"/> Implanted drug infusion device                    |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Neuro-stimulator (Deep Brain Stimulator)               | Yes <input type="checkbox"/> No <input type="checkbox"/> Aneurysm clip(s), When _____                      |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Other Stimulator: _____                                | Yes <input type="checkbox"/> No <input type="checkbox"/> Prosthesis (eye, penile, limb, etc.)              |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Catheter or feeding tube                               | Yes <input type="checkbox"/> No <input type="checkbox"/> Artificial heart valve                            |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Radiation seeds  | Yes <input type="checkbox"/> No <input type="checkbox"/> Eyelid spring or wire                             |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Medication patch (Nicotine, Nitroglycerine)            | Yes <input type="checkbox"/> No <input type="checkbox"/> Scleral Buckle                                    |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Any metallic fragment, foreign body or bullets         | Yes <input type="checkbox"/> No <input type="checkbox"/> Tattoo, permanent makeup or body piercing jewelry |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Surgical staples, clips, metallic sutures or wire mesh | Yes <input type="checkbox"/> No <input type="checkbox"/> Hearing aid (Remove before entering the MR room)  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Bone/joint pin, screw, nail, wire, plate, etc.         | Yes <input type="checkbox"/> No <input type="checkbox"/> Stent, filter, or coil                            |
| Yes <input type="checkbox"/> No <input type="checkbox"/> IUD, diaphragm, or pessary                             | Yes <input type="checkbox"/> No <input type="checkbox"/> Programmable shunt                                |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Dentures or braces                                     | Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have a history of cancer                   |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Breathing problem and motion disorder                  | Yes <input type="checkbox"/> No <input type="checkbox"/> Hair Extensions                                   |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Cochlear, otologic, or other ear implant               |  |

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6. Any other metal objects, implants, or fragments? Yes  No

If YES, name and date of implant: \_\_\_\_\_

7. Do you have any of the following conditions?  Renal disease  Kidney disease  Diabetes

8. Are you on dialysis? Yes  No

9. Do you have an allergy to Latex? Yes  No

10. Have you ever had an injection of contrast for an **MRI**? Yes  No   
(MRI contrast is *not* the same as CAT scan contrast)

If yes, did you experience any of the following Hives Yes  No

Shortness of Breath Yes  No

Fainting/Collapsing Yes  No

11. For what medical problems are you having this study? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Which side? Left  Right

### FEMALE PATIENTS

1. Is there any possibility that you are pregnant? Yes  No

2. Are you Breast Feeding? Yes  No

Sometimes MRI requires an injection of contrast. MRI contrast (Gadolinium) is administered through a small needle placed into a vein. During the administration of MRI contrast, you may experience the sensation of the contrast being injected, which is normal and expected.

MRI contrast (Gadolinium) is quite safe, however as with all medications, there is a slight risk of an allergic reaction. The physician and staff in the MRI department are trained to respond to any emergency situation that may develop. In addition, we use the safest MRI contrast, which our physicians believe is best for you. Gadolinium has no animal or food products or derivatives, sodium chloride, glucose or preservatives.

Literature on Gadolinium is available at the front desk.

I authorize Weill Cornell Imaging at NewYork-Presbyterian, its physicians and other staff to perform the prescribed examination.

I have read and understand the above information.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian)

**(FOR OFFICE USE ONLY)**  
Signature of Front Desk Staff: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Nurse/Technologist: \_\_\_\_\_ Date: \_\_\_\_\_