Weill Cornell Imaging
NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122
*Please bring all completed forms to your appointment*

*(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.**

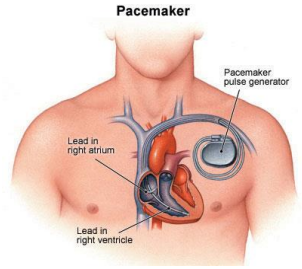
Name_____ Age_____ Weight_____ Height_____

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** ☐.

   _____ _____ _____
   _____ _____ _____

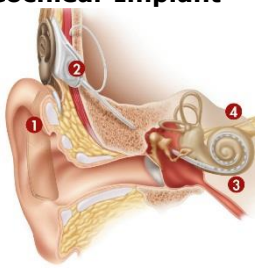
**IF YOU HAVE EITHER OF THE DEVICES BELOW YOU CANNOT HAVE AN MRI.**

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

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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: _____