UCSF Medical Center

UCSF Benioff Children's Hospital

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

MRI SCREENING

You have been scheduled for an MRI exam. The MRI scanner uses extremely strong magnetic fields that can produce heating, movement, or electric currents in ANY metal in or on your body. WARNING: This can be hazardous to you, if you have certain metal objects in or on you. Please complete this accurately and carefully.
(Please circle **Yes**/**No** responses)

1. **Do you have any metal or possibly metal containing objects in or on your body?** Yes No

If yes, check box and give details _____

- ☐ Aneurysm clip
- ☐ Cardiac pacemaker
- ☐ Implanted cardioverter defibrillator (ICD)
- ☐ Electronic implant or device
- ☐ Magnetic stent, filter, or coil
- ☐ Neurostimulator, deep brain stimulator
- ☐ Spinal cord stimulator
- ☐ Internal electrodes or wires
- ☐ Bone growth/bone fusion stimulator
- ☐ Cochlear, otologic, or other ear implant
- ☐ Insulin or other infusion pump
- ☐ Implanted drug infusion device
- ☐ Prosthesis of any kind(eye, penile, etc.)
- ☐ Heart valve prosthesis
- ☐ Artificial or prosthetic limb
- ☐ Shunt (programmable) ☐ non-programmable
- ☐ Feeding tube with mercury tip
- ☐ Radiation seeds or implants
- ☐ Medication patch
- ☐ Any metallic fragment or foreign body
- ☐ Breast tissue expander
- ☐ Surgical staples, clips
- ☐ Bone/joint pin, screw, nail, wire, plate
- ☐ IUD, diaphragm, or pessary
- ☐ Dentures, partial plates, or braces
- ☐ Permanent makeup or eyeliner
- ☐ Body piercing jewelry
- ☐ Eye lid spring or wire
- ☐ Temperature probe
- ☐ Hearing aid (remove prior to entry)

2. Have you had an injury to the eye involving a metallic object or fragment? Yes No
3. Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel)? Yes No
4. List any past surgeries/Date: _____

Height_____ Weight_____

To be completed for patients who may receive MRI CONTRAST (GADOLINIUM)

5. Have you ever had a previous reaction with intravenous contrast ("x-ray dye")? Yes No
   If yes, give details:_____
6. Have you ever had a life-threatening allergic reaction? Yes No
   If yes, give details:_____
7. Are you 60 years of age or older? Yes No
8. Do you take medication for diabetes? Yes No
9. Do you take medication for high blood pressure? Yes No
10. Do you suffer from kidney disease? Yes No
11. Do you have only one kidney or a kidney transplant? Yes No

eGFR (To be completed by RN or technologist)

"Yes" answers to Q7-11, enter eGFR within 6 weeks.

"No" answers: if eGFR is available, enter it below.

Level: _____ (mL/min/1.73mL^2)

Date: ____ /____ /_____*

< 40 | ≥ 40 or not needed

12. **FOR WOMEN:** Is there any possibility that you may be pregnant? Yes No

Please sign below to confirm that you have received, read, and understood the "Frequently Asked Questions about MRI exams". A physician is available to answer any further questions you may have.

Form completed by: _____

Signature of Patient/parent/guardian:_____

Signature of RN or Technologist:_____ Date: _____ Time: _____

STOP — Consult with Radiologist

GO — Proceed per protocol

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