CHRISTIANA SPINE CENTER IMAGING
1101 Twin C Lane Newark DE, 19713: Suite 101
Phone: 302-993-0280

MRI SAFETY SCREENING

Name (First Middle Last):_____
Today's Date: _____ Date of Birth: _____ Age: _____
Female: ___ Male: ___ Height: _____ Weight: _____

YES NO

____ ____ Have you ever had any surgical operations or procedures?
If yes please list all prior surgeries and approximate dates: _____
_____
_____

____ ____ Have you ever had an MRI? _____
If yes, when was your last MRI? _____ What facility was your MRI done at? _____
____ ____ Have you had any problems with MRIs? _____

The following items may be harmful to you during you MRI scan or may interfere with the MRI. Please provide a YES or NO for EVERY item, please indicate if you have or have had any of the following.

YES NO

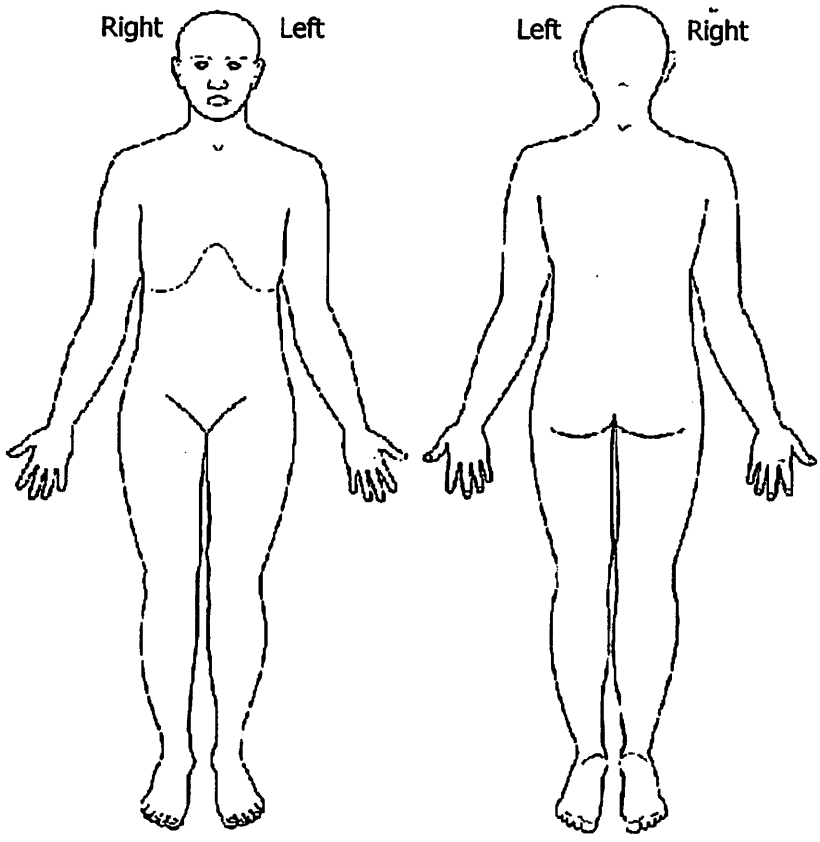
____ ____ Any type of electronic, mechanical, or magnetic implants? Type: _____Date placed:_____
____ ____ Aneurysm clip Type: _____ Date placed:_____
____ ____ Brain clip Date placed:_____
____ ____ Artificial eye
____ ____ Eyelid spring
____ ____ Hearing aid
____ ____ Cochlear implant
____ ____ Any type of ear implant
____ ____ Shunts
____ ____ Removable dentures, false teeth or partial plate
____ ____ Intracranial bolt
____ ____ Penile Implant Type: _____ Date placed:_____
____ ____ Cardiac pacemaker
____ ____ Any type of coils or filters Type: _____ Date placed:_____
____ ____ Implanted cardiac defibrillator
____ ____ Cardiac stent Type: _____ Date placed:_____
____ ____ Neurostimulator Type: _____ Date placed:_____
____ ____ Biostimulator Type: _____ Date placed:_____
____ ____ Sleep Apnea internal stimulator Type: _____ Date placed:_____
____ ____ Implanted drug pump (E.g., insulin, baclofen, chemotherapy, pain medicine)
____ ____ Spinal fixation device
____ ____ Spinal fusion procedure
____ ____ Artificial heart value Type: _____ Date placed:_____
____ ____ Aortic clip
____ ____ Carotid clip
____ ____ Any IV access port (E.g., Broviac, Port-a-cath, Hickman, Picc line)

MRI SAFETY SCREENING CONTINUED...

YES NO

____ ____ Artificial limb or joints replacements Where: _____ Date placed:_____
____ ____ Tissue expander (breast/s)
____ ____ Diaphragm, IUD, Pessary Type: _____ Date placed:_____
____ ____ Surgical mesh Location:_____
____ ____ Any type of internal electrodes or wires
____ ____ Any type of implant held in place by a magnet Type: _____
____ ____ Surgical clips / Staples
____ ____ Medication patches (e.g., Nitro, pain, nicotine, HRT, fentynal etc.)
____ ____ Bivona metal trach
____ ____ Radiation seeds (e.g., Prostate CA)
____ ____ Any implanted items (e.g., pins, rods, screws, nails, plates, wires) Where: _____
____ ____ Any other implants Type: _____ Date placed:_____
____ ____ Wig, hair implants, pins, clips
____ ____ Body piercings (Please remove)
____ ____ Tattoos / Tattoo eyeliner
____ ____ Jewelry (please remove)
____ ____ Pregnant (All woman under the age of 55 must complete a pregnancy consent form)
____ ____ Have you ever been injured by a metal object or foreign body (E.g., bullet, BB, Shrapnel)
If yes, please explain when and what happened? _____
____ ____ Have you ever had an injury to your eye/s with metal? (e.g., metal slivers, shavings, other metal objects?
If yes, when approximately did this happen? _____
If yes, have you had an X-Ray of your eyes? _____
If yes, describe what was found _____

Please mark on the drawing the location of **any metal inside your body or **site of surgical operations**.**



MRI SAFETY SCREENING CONTINUED...

YES NO

____ ____ Are you 60 or older?
____ ____ Do you have hypertension?
____ ____ Do you have heart failure or congestive heart failure (CHF)?
____ ____ Do you have diabetes?
____ ____ Are you taking medication for diabetes?
____ ____ Are you on or have you been on chemotherapy in the past?
____ ____ Do you have multiple myeloma?
____ ____ Are you taking any long-term anti-inflammatory drugs? (Non-steroidal)
____ ____ Do you have gout?
____ ____ Do you have a history of server liver disease, liver transplant, waiting for a liver transplant?
____ ____ Do you have kidney failure, kidney insufficiency, any kidney surgery, any family member with renal failure?
____ ____ Are you currently being treated for sever kidney disease? (Renal failure)
____ ____ Are you being treated by hemodialysis or peritoneal dialysis?

YES NO

____ ____ Have you ever had an MRI scan with contrast?
If yes, did you have a reaction? (Check all that apply)
Swelling(where) _____ Trouble breathing _____ Nausea or vomiting _____Hives _____
Drop of blood pressure _____ Other _____
____ ____ Are you allergic to anything (Medicine/food) Specify_____
If yes, what type of reaction? _____
____ ____ Are you taking medication for any allergies?

Patient Signature: _____ **Date:** _____