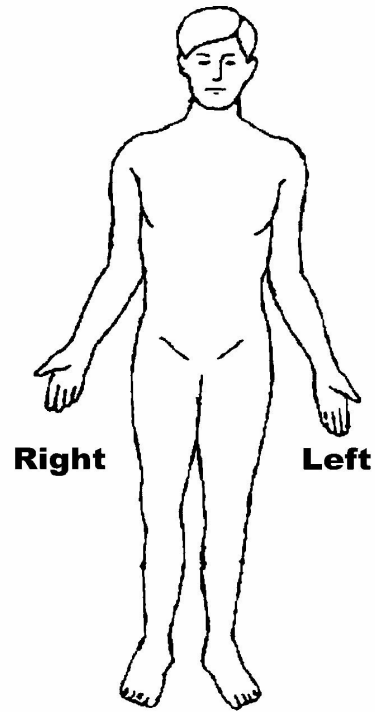


Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following. Do you have any of the following:

- | | | |
|------------------------------|-----------------------------|---|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Cardiac pacemaker |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Implanted cardiac defibrillator |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Aneurysm clip(s) |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Carotid artery vascular clamp |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Neurostimulator |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Insulin or infusion pump |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Implanted drug infusion device |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Bone growth/fusion stimulator |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Cochlear, otologic, or implant |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any type of prosthesis (eye, penile, etc.) |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heart valve prosthesis |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Artificial limb or joint |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Electrodes (on body, head, or brain) |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Intravascular stents, filters, or coils |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Shunt (spinal or intraventricular) |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Vascular access port and/or catheter |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Swan-Ganz catheter |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any implant held in place by a magnet |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Transdermal delivery system (Nitro) |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | IUD or diaphragm |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Tattooed makeup (eyeliner, lips, etc.) |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Body piercing(s) |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any metal fragments (including bullets, shrapnel) |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Internal pacing wires |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Aortic clip |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Metal or wire mesh implants |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Wire sutures or surgical staples |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Harrington rods (spine) |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Metal rods in bones |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Joint replacement_____ |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Bone/joint in, screw, nail, wire, plate |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Hearing aid (Remove before MRI) |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Dentures (Remove before MRI) |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Breathing disorder |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Movement disorder |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Claustrophobia |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Anxiety |

Other, please explain _____

Please mark on the figure below, the location of any implant or metal inside of or on your body.



Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material.

NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS OR EARPHONES DURING THE MRI EXAMINATION.

Signature/Printed name of Person Completing Form

Date ____/____/____

Form completed by: Patient Relative: _____
Name & relationship to patient

Physician or other: _____
Name & relationship to patient

Signature/Printed name of Person Reviewing Form

Date ____/____/____

To be completed by the Imaging Center Manager: Medical record number: _____
Completed by: _____ Procedure: _____ Diagnosis: _____
Clinical History: