CHRISTIE CLINIC

Department of Radiology — MRI Safety Questionnaire

Patient Name: _____ MRN:_____Weight: _____ Height: _____

Is contrast being used for this exam? Yes No If "Yes", please answer the following questions.

Renal Insufficiency	**Yes ❑ No ❑**	**Multiple myeloma**	**Yes ❑ No ❑**
Diabetic	**Yes ❑ No ❑**	**Liver disease/or liver transplant**	**Yes ❑ No ❑**
One kidney or kidney transplant	**Yes ❑ No ❑**	**Acute illness/hospitalization What: _____Date:_____**	

If the patient is 60 or older; or if there is a Yes to any of the questions above the patient will need to have a creatinine with GFR calculation within 3 months of the exam. Creatinine Value: _____ eGFR: _____ Date: _____

Please check Yes or No if you have any of the following:

Cardiac defibrillator or pacemaker Yes ❑ No ❑
Pacemaker or defibrillator retained wires Yes ❑ No ❑
LVAD device (heart pump) Yes ❑ No ❑
Medication pump, type? _____ Yes ❑ No ❑
Breast tissue expander Yes ❑ No ❑
Aneurysm clips, type? _____ Yes ❑ No ❑
Implanted electrical stimulator or mechanical device? Yes ❑ No ❑
Small bowel endoscopy capsule Yes ❑ No ❑
Metallic foreign body (bullets/shrapnel etc.) Yes ❑ No ❑

****Scheduler: If any of the above items are marked "Yes", radiology must be contacted before proceeding with scheduling this MRI. ****

Brain surgery, type? _____ Yes ❑ No ❑
Artificial heart valve/heart stents Yes ❑ No ❑
Surgical/vascular clips/grafts Yes ❑ No ❑
Coils, filters, shunts, or stents Yes ❑ No ❑
Vena Cava umbrella filter Yes ❑ No ❑
External TENS unit Yes ❑ No ❑
Eye injury involving metal Yes ❑ No ❑
Have you worked with metal without protective eyewear (ie welding and grinding) since your last MRI? Yes ❑ No ❑
- If "Yes" orbits x-ray is needed.

Eye (ocular) or ear (cochlear) implant Yes ❑ No ❑
Joint replacement, pins, screws, rods Yes ❑ No ❑
Catheter, temp monitor Yes ❑ No ❑

Tattoos/permanent makeup Yes ❑ No ❑
Personal history of cancer, type? _____ Yes ❑ No ❑
Are you pregnant? Yes ❑ No ❑
Are you breast feeding? Yes ❑ No ❑
Any surgery in the last 6 weeks? Yes ❑ No ❑

****If "Yes" to any of the following, it must be removed prior to your MRI.****

Body piercings Yes ❑ No ❑
Hair extensions/hair pieces/wig with metal Yes ❑ No ❑
Anything held with a magnet or pins Yes ❑ No ❑
Removable dental work Yes ❑ No ❑
Glucose monitor Yes ❑ No ❑
Hearing aids Yes ❑ No ❑
Prosthetic devices Yes ❑ No ❑
Medication or nicotine skin patches Yes ❑ No ❑
(Many types of patches need to be removed prior to MRI)
Anything in or on your body that you weren't born with that is not listed above? Yes ❑ No ❑

Do you have any special needs that would require additional time, for example, wheelchair, interpreter, etc.? Yes ❑ No ❑
Claustrophobic or weigh over 300 lbs. Yes ❑ No ❑
- If "Yes" schedule in Urbana or Fields.

Allergic to MRI IV contrast/gadolinium? Yes ❑ No ❑
- If "Yes", the patient should be pre-medicated and have a driver.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Patient Name (Printed): _____ Birth Date: _____

Patient Signature: _____ (Parent or Guardian, Relationship): _____ Date: _____

Christie Clinic team member who completed this form with the patient: The above information has been reviewed and approved by me prior to exam. If this form is done verbally with the patient, the patient will sign this form when they arrive onsite.

Team Member Name: _____ Date: _____

Please fax completed form to 217-366-5645.

7.7.20