TALLAHASSEE DIAGNOSTIC IMAGING
MRI SCREENING FORM

PATIENT NAME: ___________________________________________ DATE: ________________________

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.

- Yes  No  Cardiac pacemaker or internal pacing wires
- Yes  No  Implanted cardiac defibrillator or internal pacing wires
- Yes  No  Aneurysm clip(s) or coils
- Yes  No  Neuro-stimulator
- Yes  No  Implanted drug infusion device (insulin or infusion pump)
- Yes  No  Bone growth/fusion stimulator
- Yes  No  Cochlear, otologic, or ear implant
- Yes  No  Any type of prosthesis (eye, penile, etc.)
- Yes  No  Heart valve prosthesis
- Yes  No  Breast Tissue Expander(s)
- Yes  No  Electrodes (on body, head, or brain)
- Yes  No  Intravascular stents, filters, or coils
- Yes  No  Shunt (spinal or intra-ventricular)
- Yes  No  Vascular access port (Infusaport)
- Yes  No  Any implant held in place by a magnet
- Yes  No  Transdermal delivery system (Nitro or pain medicine patch)
- Yes  No  Retinal Buckle for Retinal Detachment
- Yes  No  Body piercing(s)
- Yes  No  Any metal fragments (shrapnel, bullet, foreign body, etc.)
- Yes  No  Aortic clip
- Yes  No  Wire sutures or surgical staples
- Yes  No  Harrington rods (spine) for Scoliosis Correction Surgery
- Yes  No  Metal rods in bones
- Yes  No  Joint replacement __________________________
- Yes  No  Bone/joint pin, screw, nail, wire, plate
- Yes  No  Hearing aid (Remove before MRI)
- Yes  No  Dentures (Remove before MRI)
- Yes  No  Claustrophobia
- Yes  No  Anxiety

Reviewed by: TDI Staff

Front Desk Staff Initials: ___________________________

Medical Assistant Initials: __________________________

MR Technologist Initials: ___________________________

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

(please continue to the other side of this form.)
For All Patients:

1. Do you have any drug allergies? □ No □ Yes

   If “Yes”, please list: _______________________________________

2. Have you ever had a reaction to contrast material (dye) for ANY medical test? □ No □ Yes

   If “Yes”, what test did you have? ________________________________

   Describe the reaction: _________________________________________

3. Please circle any of the conditions you have or have ever had:
   - Kidney disease
   - Diabetes
   - Multiple myeloma
   - Lupus
   - Kidney transplant
   - Dialysis
   - Sickle cell anemia
   - Cancer/tumor
   - Kidney failure
   - Stroke
   - Heart failure
   - High blood pressure
   - One kidney
   - Asthma
   - Tuberculosis

4. Have you ever worked with metal (grinding, fabrication, etc.) or have you ever had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings or metallic foreign body)? □ No □ Yes

5. If you answered “Yes”, was the metallic object removed by a physician? □ No □ Yes

6. If you answered “Yes”, were you told by the physician that he/she removed all of the metal? □ No □ Yes

For Female Patients:

1. Are you or could you be pregnant or experiencing a late menstrual period? □ No □ Yes

   Date of last menstrual period: _____/_____/_______

2. Are you breastfeeding? □ No □ Yes

   Date: _____/_____/_______

   Signature of Person Completing Form

   Form completed by: □ Patient □ Other: ______________________________

   ______________________________ Date: _____/_____/_______

   TDI Employee Reviewing MRI Safety Form