KAISER PERMANENTE®

MRI Screening Questionnaire

Name: MRN #: Date:

Weight: kg	Height:		
Please explain the reason for this MRI scan/procedure?			
Have you had a previous exam related to this problem? When: Where:			Yes No
Have you taken any medications today to reduce your anxiety	for this MRI exam?		Yes No
What previous procedures/surgeries have you had:			
When:	Where:		
Have you ever had procedures/surgeries involving/performed	2		🗌 YES 🗌 No
When:	Where:		
Have you ever received contrast dye for an MRI study? If Yes, did you ever have any discomfort, ill-effect or allergic re	paction (Llivos Eaint	ting otc)	Yes No YES No No
MRI Hazard Checklist:			
		Motallic artificial boart value	YES No
Do you have any of the following?		Metallic artificial heart valve	
A cardiac pacemaker		y	
Wires or electrodes			🗌 YES 🗌 No
Implanted cardiac monitor and/or defibrillator (AICD)			
Have you ever had an injury from a metal object or foreign boo	5	NO	
Female Patients (except post-menopausal/post-hysterectomy	··	No	
Are you pregnant? Are you breast feeding?	□ YES □ □ Yes □		
Date of last menstrual period:			
HARD STOP: If any above questions are answered "YE	S (bolded)" above,	hold MRI and have ordering physician consul	t with Radiologist.
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Do you have or have you had any of the following?			
Medication Patch	Yes No	Shunt	Yes No
A. Medication patch removed		Artificial limb or joint	🗌 Yes 🗌 No
Any type of electronic, mechanical or magnetic implant? Type:	Yes No	What and where Tissue expander	Yes 🗌 No
Neurostimulator	🗌 Yes 🗌 No		
Biostimulator	🗌 Yes 🗌 No		🗌 Yes 🔲 No
Туре:		Surgical Mesh	🗌 Yes 🗌 No
Cochlear implant		Location:	
Any type of ear implant Hearing aid	Yes No	Body piercing Location:	🗌 Yes 🗌 No
Implanted drug pump (e.g., insulin, chemotherapy, pain meds)	= =	Wig, hair implants	Yes 🗌 No
Halo Vest	Yes No		Yes No
Spinal fixation device or Spinal fusion procedure	🗌 Yes 📃 No	Radiation seeds (e.g., cancer treatment)	🗌 Yes 📃 No
Any type of vascular coil, filter, or stent	Yes No	Any implanted items (pins, rods, screws)	
Type: Any type of metal object (e.g., shrapnel, bullet, BB)	🗌 Yes 🗌 No	Any Hair accessories Jewelry	☐ Yes ☐ No ☐ Yes ☐ No
Penile implant		Any other implantable items	
Artificial eye	Yes No	Type:	
Eyelid spring	🗌 Yes 📃 No	Temperature sensing foley catheter?	🗌 Yes 🗌 No
Any type of surgical clip, staples, or aneurysm clips	Yes No		
Information provided by:			
Information provided by: Patient Medical Record	E Family	Signature of Patient/Responsible Party	
Verification of patient safety by wand clearance complete. Staff initials (MRI Technologist)			Daternine
Licensed staff/RN verifying information and NUID Date/Time		MRI technologist verifying information and	NUID Date/Time
Distribution: Eastern Washington to ACN-AC3; Western Washington to RCS			