

# 1.5T MR PRE-PROCEDURE SCREENING FORM

Richard M. Lucas Center for MRS/I  
Department of Radiology, Stanford University School of Medicine  
1201 Welch Road, MC 5488, Room P273, Stanford, CA 94305-5488  
(650) 723-9529, 723-8205

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Last name First name M.I.

Birthdate \_\_\_\_\_  Female  Male Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone (H)(\_\_\_\_\_) (W)(\_\_\_\_\_) \_\_\_\_\_

Physician's name & address \_\_\_\_\_

1. Have you ever had surgery or other invasive procedures?  Yes  No If yes, please list below.  
Type: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Type: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

2. Have you had any previous studies?  Yes  No If yes, please list below.  
Area of Body Date Facility Name & Location  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_

3. Have you ever worked as a machinist, metal worker, or in any profession or hobby grinding metal?  Yes  No  
had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings, or foreign body)?  Yes  No

4. Are you pregnant, experiencing a late menstrual period, or having fertility treatments?  Yes  No

5. Are you currently taking or have recently taken any medication?  Yes  No Please list: \_\_\_\_\_

6. Do you have drug allergies or have you had an allergic reaction?  Yes  No Please list: \_\_\_\_\_

**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.**

- |  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac pacemaker                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Shrapnel, buckshot, or bullets             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted cardiac defibrillator         | <input type="checkbox"/> Yes <input type="checkbox"/> No IUD or diaphragm                           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aneurysm clip or brain clip             | <input type="checkbox"/> Yes <input type="checkbox"/> No Pessary or bladder ring                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Carotid artery vascular clamp           | <input type="checkbox"/> Yes <input type="checkbox"/> No Tattooed eyeliner or eyebrows              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Neurostimulator                         | <input type="checkbox"/> Yes <input type="checkbox"/> No Body piercing(s)                           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin or infusion pump                | <input type="checkbox"/> Yes <input type="checkbox"/> No Metal fragments (eye, head, ear, skin)     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted drug infusion device          | <input type="checkbox"/> Yes <input type="checkbox"/> No Facelift or other cosmetic surgery on body |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Spinal fusion stimulator                | <input type="checkbox"/> Yes <input type="checkbox"/> No Internal pacing wires                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear, otologic, or ear implant      | <input type="checkbox"/> Yes <input type="checkbox"/> No Aortic clips                               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ear tubes                               | <input type="checkbox"/> Yes <input type="checkbox"/> No Venous umbrella                            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthesis (eye/orbital, penile, etc.)  | <input type="checkbox"/> Yes <input type="checkbox"/> No Metal or wire mesh implants                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implant held in place by a magnet       | <input type="checkbox"/> Yes <input type="checkbox"/> No Wire sutures or surgical staples           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart valve prosthesis                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Harrington rods (spine)                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial limb or joint                | <input type="checkbox"/> Yes <input type="checkbox"/> No Metal rods in bones; joint replacements    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Other implants in body or head          | <input type="checkbox"/> Yes <input type="checkbox"/> No Bone/joint pin, screw, nail, wire, plate   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Electrodes (on body, head or brain)     | <input type="checkbox"/> Yes <input type="checkbox"/> No Wig, toupee, or hair implants              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Intravascular stents, filters, or coils | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing aid ( <b>Remove before scan</b> )  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Shunt (spinal or intraventricular)      | <input type="checkbox"/> Yes <input type="checkbox"/> No Dentures ( <b>Remove before scan</b> )     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Vascular access port or catheters       | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma or breathing disorders              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Swan-Ganz catheter                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures or motion disorders               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Transdermal delivery system (Nitro.)    | <input type="checkbox"/> Yes <input type="checkbox"/> No Claustrophobia                             |

Please remove **all metallic objects** before MR examination 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.

**Earplugs are required during the MRI examination.**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Signature of Person Completing Form \_\_\_\_\_ Date

Form Completed by:  Patient / Volunteer  Relative: \_\_\_\_\_  
 Physician: \_\_\_\_\_  Other: \_\_\_\_\_