MRI SCREENING QUESTIONNAIRE

If you have any questions pertaining to this screening form, please contact your MRI department.
(BMCS ext 2796 BMCE ext 8331)

Baptist Health

PATIENT INFORMATION

Exam:_____ Height:_____ Weight:_____

Is there any possibility you could be pregnant? YES NO Date of last menstrual cycle:_____

Do you have any of the following?

If YES to any question, check box and document in comment section; if NO to any question, leave blank and note in the bottom row.	**1st Screener**	**2nd Screener**	**Location/Type**
❑ Pacemaker/Defibrillator/ICD			
❑ Brain or Aneurysm Clips			
❑ Metallic Surgical Staples			
❑ Metal injury to Eyes or Body (Shrapnel/Shavings)			
❑ Partials/Dentures			
❑ Body Piercing Jewelry **(must be removed)** tattoos (and permanent makeup)			
❑ Electronically, mechanically, or magnetically activated device			
❑ Metallic Implants/Prosthetics (any type: eye, limb, joint)			
❑ Prosthesis (eye, penile, etc.)			
❑ Transdermal/medication patch (Nicotine, Nitroglycerine, Birth Control)			
❑ Stents			
❑ Vascular Graft/Filter			
❑ Heart Valve			
❑ Infusion pump (insulin, pain, etc.)			
❑ Shunts			
❑ Stimulator (bone, neuron, etc.)			
❑ Hearing Aids/Ear Implants			
❑ Gastric pacemaker			
❑ Internal Electrodes			
☐ ***None of the above (initial in the box)**			

List Medication Allergies:_____

_____ _____
Signature of Patient/Responsible Party (relationship) Date and Time

Please leave any contact information for any responsible party with the MR department

_____ _____
1st Interviewer/Title Date and Time

_____ _____
2nd Interviewer/MR Technologist Date and Time

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