CentraCare™
St. Cloud Hospital

The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment if they have certain metallic, electronic, magnetic or mechanical implants, devices or objects. Therefore, all individuals are required to fill out this form **BEFORE** entering the MR environment. **Be advised, the MRI magnet is ALWAYS on.**

TO BE FILLED OUT BY MRI STAFF

AREA TO BE EXAMINED: _____ Magnet: _____

SYMPTOMS/DIAGNOSIS: _____ eGFR: _____

Date of lab: _____

PATIENT, PLEASE INDICATE BELOW IF YOU HAVE ANY OF THE FOLLOWING AND ANSWER THE FOLLOWING QUESTIONS:

PATIENT'S WEIGHT_____

Please circle appropriate box

PATIENT'S HEIGHT_____

Yes	No	Cardiac pacemaker, ICD or Loop Recorder
Yes	No	Aneurysm clips/coils
Yes	No	Neuro/bone/bladder stimulation device
Yes	No	Shunt (spinal or intraventricular)
Yes	No	Welder/grinder or metal in eye
Yes	No	Abandoned wires/electrodes/leads

Yes	No	Ear (Cochlear, Stapes or other implants)
Yes	No	Eye (eyelid spring/weight eye buckle)
Yes	No	Magnetic eyelashes and/or eyeliner

Yes	No	Diabetic
Yes	No	Glucose Monitor
Yes	No	External Drug Pump (insulin)
Yes	No	Implanted Drug Pump (Chemo, Pain)
Yes	No	History of kidney/renal disease?
Yes	No	Are you on dialysis?
Yes	No	History of kidney transplant?

Yes	No	IVC Filter
Yes	No	Metallic stent or coil (blood vessels, heart, legs)
Yes	No	Vascuar access (port, PICC, Swan-Ganz)
Yes	No	Thermodilution catheter
Yes	No	Gastrointestinal clips (hemostatic, endoscopic)

Yes	No	Penile Prosthetic
Yes	No	Chance of Pregnancy
Yes	No	Birth Control Devices(IUD i.e. Mirena, Diaphragm)
Yes	No	Tissue Expander (Breast)
Yes	No	Are you breastfeeding?

Yes	No	Any prosthesis (eye, heart valve, limb)
Yes	No	Implanted mechanical devices (joint replacement)
Yes	No	Bone/joint pins, screws, wires or plates etc.
Yes	No	Injured by metal object (shrapnel, bullet, BB)

Yes	No	Claustrophobia, if yes, is sedation required?

Yes	No	Hearing aid (remove before scan please)
Yes	No	Body piercing, tattoo or permanent makeup
Yes	No	Dentures or partial plates
Yes	No	Medication patch (nicotine, contraceptive, pain)
Yes	No	Silver wound dressings

Injury/Type and Date: _____

Surgery on Area: _____

Dates of surgeries: _____

Previous MRIs: _____

If you have any questions, please Speak Up

To the best of my knowledge, I've read and understand the entire contents of this form. I've had the opportunity to ask questions regarding the information on this form. You will be asked to change into Hospital attire and remove all jewelry, wallet, phones, hair pins, wig and hearing aids.

Patient or Responsible Person Signature **Technologist Signature** **Date**