Jewish Hospital & St. Mary's HealthCare

Safety Screening Form
MR Hazard Checklist

SAFETY SCREENING FORM FOR MAGNETIC RESONANCE (MR) PROCEDURES

Date: _____

Height:_____ Weight: _____

Circle Yes or No

Y N Have you ever had an MRI examination before and had a problem?

If yes, please describe _____

Y N Have you ever been injured by a metal object or foreign body (e.g. bullet, BB, shrapnel)?

If yes, please describe _____

_____

Y N Have you ever had an injury from a metal object in your eye (metal slivers, metals shavings other metal object)?

If yes, did you seek medical attention?_____

If yes, describe what was found _____

Y N Do you have a history of kidney disease, asthma, or other allergic respiratory disease?

Y N Do you have any drug allergies?

If yes please list drugs_____

Y N Have you ever received a contrast?

If yes, please describe _____

Y N Are you breast feeding?

Date of last menstrual period _____

Post-menopausal _____

Y N Are you pregnant?

Safe MR Practices

Y N Any type of implant held in place by a magnet?

Type_____

Y N Any type of surgical clip or staple?

Y N Any IV access port (e.g. broviac, Port-a Cath PICC line)

Y N Medication patch (e.g. nitroglycerine, nicotine)

Y N Shunt

Y N Artificial limb or joint

What and where _____

Y N Tissue expander (e.g. breast)

Y N Removable dentures, false teeth or partial plate

Y N Diaphragm, IUD, pessary

Type_____

Y N Surgical mesh

Location _____

Y N Body piercing

Location _____

Y N Wig or hair implants

Y N Tattoos or tattooed eyeliner

Y N Radiation seeds

Y N Jewelry (e.g., bobby pins, barrettes, clips)

Y N Any other type of implanted item

Type_____

Hazard Checklist

Do you have any of the following devices?

Y N Endotracheal tube

Y N Swan-Ganz catheter

Y N Extraventricular device

Y N Arterial line transducer

Y N Foley catheter w/temperature sensor and/or metal clamp

Y N Rectal probe

Y N Esophageal probe

Y N Tracheostomy tube

Y N Guidewires

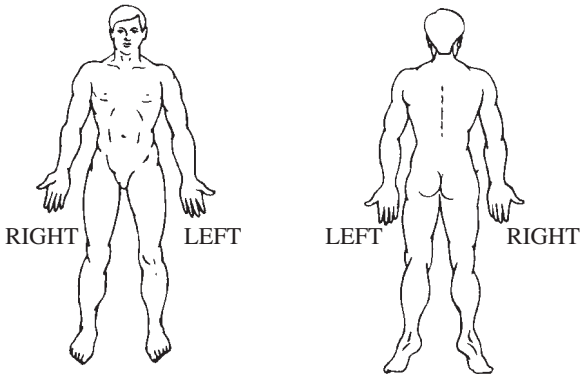
Radiology Worksheet

SCAN TO PACS

Jewish Hospital & St. Mary's HealthCare

MR Hazard Checklist

Please mark on the drawing indicating the location **of any metal inside your body or site of surgical operation.**
The following items may be harmful to you during your MR scan or may interfere with the MR examination. You must provide a "yes" or "no" for every item. Please indicate if you have or have had any of the following:



Please review the questions above, then sign the bottom of this form. If the patient is unable to sign, the person filling out this form must sign and take full responsibility for correct answers.

Circle Yes or No

Y N Any type of electronic, mechanical or magnetic implant
Type_____
Y N Cardiac pacemaker
Y N Aneurysm clip
Y N Implantable cardiac defibrillator
Y N Neurostimulator
Y N Biostimulator
Type_____
Y N Any type of internal electrodes or wires
Y N Cochlear implant
Y N Hearing aid
Y N Implanted drug pump (e.g., insulin, baclofen, Chemotherapy, pain medicine)
Y N Halo vest
Y N Spinal fixation device
Y N Spinal fusion procedure
Y N Any type of coil, filter, or stent
Type_____
Y N Any type of metal object (e.g., shrapnel, bullet, BB)
Y N Artificial heart valve
Y N Any type of ear implant
Y N Penile implant
Y N Artificial eye
Y N Eyelid spring

I have reviewed the above: _____Date: _____
(Patient's signature)

_____ _____
(Responsible Person) (Relationship to Patient)

Technologist Reviewed: _____Date: _____

Scanning Technologist:_____

TECHNOLOGIST USE ONLY:
Lab Results: GFR _____
Gadolinium: Type: _____
Lot No: _____
Exp. Date: _____
Amount:_____

Circle Used:
Magnevist
Multihance
Eovist
Gastromark
Other _____

Injection Complications: Y N If yes, describe _____
Circle ALL risk factors: Age greater than 60, Kidney disease, 1 Kidney, HTN, DM, Recent Chemo
Technologist Initials: _____
INPATIENT USE ONLY:

To Be Completed by RN

Does the patient have orders for pre-med? Yes [ ] No [ ]
RN:_____EXT:
FAX COPY OF ORDER AND THIS FORM TO:
JEWISH PHONE EXT: 4001 FAX: EXT 4056
SMEH: 361-6577 FAX: 367-3331
JHS PHONE: 647-4192 FAX: 647-4390
DON'T FORGET TO PLACE THE ORDER IN CLINICIAN VALET.

Radiology Worksheet F1245

SCAN TO PACS