BARNES-JEWISH Hospital BJC HealthCare

Children's HOSPITAL • ST. LOUIS BJC HealthCare

Washington University in St. Louis SCHOOL OF MEDICINE

MRI SCREENING QUESTIONNAIRE: PATIENT

PATIENT IDENTIFICATION

PATIENT NAME:	DATE OF BIRTH:	GENDER: ☐ Male ☐ Female

The following items may be harmful to you during your MR scan or may interfere with the MRI examination. Please check "Yes" or "No" to indicate whether you have or have had any of the following. Remove ALL metallic objects prior to MRI. Please provide any implant card.

Cardiac Pacemaker	☐ Yes	☐ No	Pacer Wires	☐ Yes	☐ No
Implanted Cardiac Defibrillator	☐ Yes	☐ No	Cochlear or Other Ear Implants	☐ Yes	☐ No
Tissue Expanders (Breast or other)	☐ Yes	☐ No	Eyelid Spring or Retinal Tacks	☐ Yes	☐ No

If you responded "Yes" to any of the above, you may NOT be eligible for MRI. Please contact a representative in MRI at 314-362-1695 or talk to a representative at the reception desk.

Age Weight Height			Claustrophobic	☐ Yes	☐ No
Allergy to MRI Contrast	☐ Yes	☐ No	If claustrophobic, then contact your MD prior to your MRI exam for anxiety-reducing medication.		
Pregnant or Breastfeeding	☐ Yes	☐ No			
Kidney Disease/Dialysis	☐ Yes	☐ No	Tracheotomy	☐ Yes	☐ No
Metal in Eye Date: Type: (if known):	☐ Yes	☐ No	Tattoos, Tattoo Eye or Lip Liner	☐ Yes	☐ No
Endoscopy Camera Pill Date: Type: (if known):	☐ Yes	☐ No	Bullets, BBs, Shrapnel Date: Location:	☐ Yes	☐ No
Programmable Shunt Date: Type: (if known):	☐ Yes	☐ No	Aneurysm Clip Date: Type: (if known):	☐ Yes	☐ No
Neurostimulator Date: Type: (if known):	☐ Yes	☐ No	Any Implanted Drug Pumps Date: Type: (if known):	☐ Yes	☐ No
Penile Implant Date: Type: (if known):	☐ Yes	☐ No	Any Implanted Metal or Device Date: Type: (if known):	☐ Yes	☐ No
Coils, filters or stents Date: Type: (if known):	☐ Yes	☐ No	Artificial Heart Valve Date: Type: (if known):	☐ Yes	☐ No

If you responded "Yes" to any of the items below, for your safety, the items MUST be removed.

Hearing Aid	☐ Yes	☐ No	False Teeth or Partial Plate	☐ Yes	☐ No
Medication Patch	☐ Yes	☐ No	Body Piercing	☐ Yes	☐ No
Artificial Limb	☐ Yes	☐ No	Wig, Hair Implants, Clips or Pins	☐ Yes	☐ No

LIST ALL SURGERIES:	COMMENTS:

Person Completing Form: _____ _____ Date: _____ Time: _____
SIGNATURE **REQUIRED**/TITLE PRINTED NAME **REQUIRED**

Form Completed By: ☐ Patient ☐ Clinician or RN

Date of Exam: _____ **Charge Technologist Signature:** _____ Time: _____

MR Technologist Signature: _____ Time: _____

DO NOT WRITE BELOW THIS LINE