

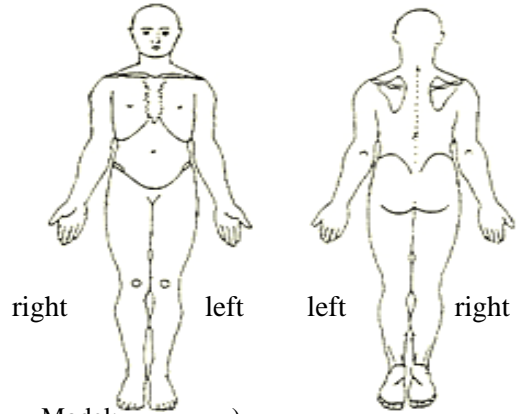
HAZARD CHECKLIST

Patient Name: _____ DOB: _____

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MR procedure. **DO NOT ENTER** the MR unit if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR unit.

- | | | |
|-----|-----|---|
| Yes | No | |
| ___ | ___ | Aneurysm clip(s) (surgery documentation needed) |
| ___ | ___ | Cardiac pacemaker (past or present) |
| ___ | ___ | Electronic implant or device |
| ___ | ___ | Implanted cardiac defibrillator (past or present) |
| ___ | ___ | Neurostimulator system |
| ___ | ___ | Magnetically-activated implant or device |
| ___ | ___ | Spinal cord stimulator |
| ___ | ___ | Internal electrodes or wires |
| ___ | ___ | Bone growth/bone fusion stimulator |
| ___ | ___ | Cochlear, otologic, or other ear implant |
| ___ | ___ | Insulin or other infusion pump |
| ___ | ___ | Implanted drug infusion device |
| ___ | ___ | Any type of prosthesis (eye, penile, etc.) |
| ___ | ___ | Heart valve prosthesis (Date: _____ Make: _____ Model: _____) |
| ___ | ___ | Metallic stent, filter, or coil (Date: _____ Make: _____ Model: _____) |
| ___ | ___ | Eyelid spring or wire |
| ___ | ___ | Artificial or prosthetic limb |
| ___ | ___ | Shunt (spinal or intraventricular) |
| ___ | ___ | Vascular access port and/or catheter |
| ___ | ___ | Radiation seeds or implants |
| ___ | ___ | Swan-Ganz or thermodilution catheter |
| ___ | ___ | Medication patch (Nicotine, Nitroglycerine) |
| ___ | ___ | Metallic fragment or foreign body (metal shavings in eye or any part of body) |
| ___ | ___ | Tissue expander (e.g., breast) |
| ___ | ___ | Surgical staples, clips, or metallic sutures |
| ___ | ___ | Joint replacement (hip, knee, etc.) |
| ___ | ___ | Bone/joint pin, screw, nail, wire, plate, etc. |
| ___ | ___ | IUD, diaphragm, or pessary |
| ___ | ___ | Tattoo or permanent make-up |
| ___ | ___ | Other implant _____ |
| ___ | ___ | Breathing problem or motion disorder |

Please mark on the figure(s) below to show location of any implant or metal inside of or on your body.



- | | | |
|-----|-----|--|
| YES | NO | |
| ___ | ___ | Wire mesh implant |
| ___ | ___ | Body piercing jewelry |
| ___ | ___ | Dentures or partial plates |
| ___ | ___ | Hearing aid |
| ___ | ___ | <i>(Remove before entering MRI unit)</i> |
| ___ | ___ | Hair extensions / wigs |
| ___ | ___ | Claustrophobia |
| ___ | ___ | LVAD Device (Heart pump) |
| ___ | ___ | Hypertension (High blood pressure) |
| ___ | ___ | History of Falls |
| ___ | ___ | History of liver disease/ liver transplant or pending transplant |
| ___ | ___ | <i>(No contrast for perioperative liver pts.)</i> |
| ___ | ___ | History of Breast Cancer |
| ___ | ___ | If yes, any lymph nodes removed? Yes No |

Do you have a history of:

- Diabetes ___Yes ___No Kidney problems ___Yes ___No High blood pressure ___Yes ___No
 Liver disease ___Yes ___No Multiple myeloma ___Yes ___No Collagen vascular disease ___Yes ___No
 Asthma or other allergic respiratory disease ___Yes ___No Drug allergies ___Yes ___No
 Are you taking any medications to prevent blood clots (anti-coagulants) ___Yes ___No

- If you answered **YES** to any of the above questions, please call our office.
- Please be sure to bring any documentation for any surgically implanted devices you may have.

Screeener's Signature: _____ Date: _____

Technologist's Signature: _____ Date: _____

Signature: _____ Date: _____