Bronson Healthcare Group
MRI Patient Screening Form

Patient Information Sticker

Do you have any of the following? Please indicate yes or no.

Yes	No		Yes	No		Yes	No	
		Aneurysm clips			Aneurysm coils			Artificial limb or joint
		Breast implants			Bullets, BBs, pellets under your skin			Cataract implant
		Cochlear implant			Defibrillator			Ear implant
		Epidural catheter			Eye implants			Eye weights
		Hearing aids			Implanted orthopedic devices (pins, screws, rods, plates)			Internal wires
		IUD			Medication patch on your skin			Pacemaker
		Penile prosthesis			Piercings			Programmable shunt
		Stents			Swan Ganz catheter			Surgical clip/staple
		Tattoos (eyeliner included)			Tissue expanders			Tracheostomy
		Vena cava filter			Claustrophobia			Diabetes
		Hypertension			Sickle cell disease			

Do you have any other implanted items or devices? If so, please list:

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Please answer the questions below by circling yes or no or filling in the blank:

Are you pregnant? No Yes If so, how many weeks? __________

Are you breastfeeding? No Yes

Are you on dialysis? No Yes

Do you have any pieces of metal in your eye? No Yes

This may be due to an accident or injury.

Have you worked with metal or metal shavings? No Yes

Have you had a colonoscopy procedure in the last 8 weeks? No Yes

Have you had a liver or kidney transplant? No Yes

Do you have kidney disease, kidney cancer or a single kidney? No Yes

BRONSON

Patient or Guardian

I agree that the above information is correct. I have read and understand the contents of this form.

I have had the opportunity to ask questions regarding the information on this form for my MRI procedure that is about to be performed.

Signature of Patient or Guardian:________________________ Date:__________ Time:__________

MRI Staff/Department use only

Final patient screening check done prior to Zone 3: ☐

Staff comments:____

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Reviewed with patient by: ____________________________ Date:___________ Time:__________