

**MRI SAFETY CHECKLIST (PART A - PATIENT SCREENING)**  
**Naval Health Clinic Charleston Radiology Department**

Please complete this form to aid in safety screening prior to your procedure. The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body. Some metal objects can interfere with your scan or even be dangerous, so please answer the following questions carefully. Additionally your Physician or Radiologist may deem it necessary for you to have an IV injection of a contrast liquid containing gadolinium to improve the quality of your MRI examination. Although gadolinium contrast agents have been used safely in millions of patients, minor reactions (primarily headache and nausea), serious and life threatening reactions have occurred. The radiologist and technologists are aware of these possibilities and emergency equipment and drugs are readily available if necessary. Your doctor is aware of the risks and has determined that the diagnostic benefits outweigh the potential risks involved. If you have any questions, please do not hesitate to ask the technologist or a radiologist who will be performing the study.

**Patient's Name:** \_\_\_\_\_ **Phone #:**(\_\_\_\_)\_\_\_\_\_

**Age/birth date:**\_\_\_\_\_/\_\_\_\_\_ **Weight:**\_\_\_\_\_ **Height:**\_\_\_\_\_ **Sex:**\_\_\_\_\_

**Exam ordered:**\_\_\_\_\_ **Diagnosis / Question:**\_\_\_\_\_

**Referring source( MD /clinic):**\_\_\_\_\_

**Please list all allergies (medications, latex, barium sulfate, foods):**\_\_\_\_\_

**List any undocumented medications currently taking:**\_\_\_\_\_

**PATIENT HISTORY SCREENING**

- Yes**  **No** Have you ever had an MRI examination?
  - Yes**  **No** Have you ever had an operation or surgical procedure?
- Please list \_\_\_\_\_

- Yes**  **No** Have you ever been a machinist, welder, or metal-worker.
- Yes**  **No** Have you ever been hit in the face or eye with a piece of metal (including metal shavings, silvers, bullets, or BBs)?
- Yes**  **No** Have you ever had a piece of metal removed from your eye?
- Yes**  **No** Are you pregnant, possibly pregnant, or breastfeeding?
- Yes**  **No** Do you weigh over 290 pounds?
- Yes**  **No** Do you have claustrophobia or fear of enclosed spaces?

**DO YOU HAVE ANY OF THESE ITEMS IN YOUR BODY?**

- Yes**  **No** Pacemaker, wires, defibrillator.
- Yes**  **No** Brain/aneurysm clip
- Yes**  **No** Eye implant, ear implant or hearing aid
- Yes**  **No** Medication patch
- Yes**  **No** Electrical stimulator for nerves or bone (Tens-unit)
- Yes**  **No** Bullets, BBs, or pellets
- Yes**  **No** Metal shrapnel or fragments
- Yes**  **No** Magnetic implant anywhere
- Yes**  **No** Infusion pump
- Yes**  **No** Coil, Filer, wire or stent in blood vessel
- Yes**  **No** Tattoos or piercings
- Yes**  **No** Implanted catheter or tube
- Yes**  **No** Artificial heart valve
- Yes**  **No** Penile prosthesis
- Yes**  **No** Shunt or venous filter.
- Yes**  **No** False teeth, retainers, or magnetic braces
- Yes**  **No** Surgical clips, staples, wires, mesh, or sutures
- Yes**  **No** Diaphragm or intrauterine device
- Yes**  **No** Orthopedic hardware (plates, screws, pins, rods, wires)
- Yes**  **No** Small bowel endoscopy capsule.
- Yes**  **No** Glitter make up
- Yes**  **No** Wound dressing (i.e. acticoat 7)
- Yes**  **No** Dental braces or removable dental work.

**CLAUSTROPHOBIA SCREENING:**

Patients who are prone to claustrophobia will often have problems during an MRI scan. Please indicate if you are claustrophobic.

YES \_\_\_\_\_ NO \_\_\_\_\_

**GADOLINIUM CONTRAST SCREENING**

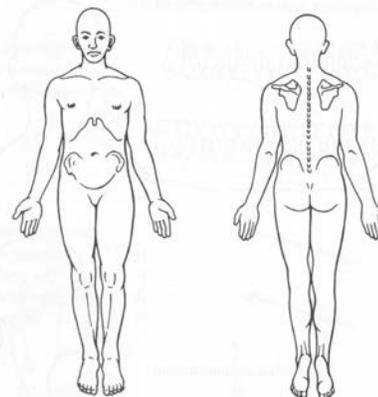
As part of your examination, the MR radiologist may deem it advisable to give you an I.V. injection of a contrast agent containing gadolinium. This injection may help the physician more accurately diagnose your condition.

- Yes**  **No** Have you ever had allergic reaction to gadolinium contrast?
- Yes**  **No** Do you have a history of asthma or emphysema?
- Yes**  **No** Do you have a history of kidney disease or failure?

Where is your pain?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please indicate areas  
 Of pain on diagram-->



**MRI CONTRAST USE SAFETY CHECKLIST (PART B - STAFF SCREENING)**  
**Naval Health Clinic Charleston Radiology Department**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Patient's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PRE CONTRAST ADMINISTRATION CHECK LIST:**

- |                                                                                                                                               |            |           |
|-----------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| 1. Did the patient answer yes to any question in <b>part A?</b><br>(If yes consult attending radiologist <b>BEFORE EXAM</b> )                 | <b>Yes</b> | <b>No</b> |
| 2. Patient allergies/medications/medical conditions reconciled and reviewed with medical record and patient to avoid complications with exam? | <b>Yes</b> | <b>No</b> |
| 3. Patients identification verified by comparing record with patient's name and date of birth?                                                | <b>Yes</b> | <b>No</b> |

**SCREENING ORBIT XRAYS CLEARED BY:** \_\_\_\_\_

**RADIOLOGIST'S EXAM PROTOCOL**

**Exam/views:** \_\_\_\_\_

\_\_\_\_\_ GADOLINIUM (Magnevist) give \_\_\_\_\_ ml IV.

\_\_\_\_\_ **Radiologist's signature/date/stamp**

**IV CONTRAST UTILIZED**

\_\_\_\_\_ ml of GADOLINIUM contrast was administered via  
(dose)

\_\_\_\_\_ at \_\_\_\_\_ on \_\_\_\_\_.  
(route & site) (time) (date)

Contrast Lot#: \_\_\_\_\_ Expiration date: \_\_\_\_\_

IV contrast administered by: \_\_\_\_\_

Administered under the direct supervision of: \_\_\_\_\_

Complications / modifications to exam ordered: \_\_\_\_\_

Post injection complications (if any): \_\_\_\_\_

Treatment rendered including any medication given and time: \_\_\_\_\_

Technologist signature/comments: \_\_\_\_\_/\_\_\_\_\_