PALM BEACH HEALTH NETWORK SCHOOL OF MEDICAL IMAGING

MRI Screening Form

Name:_____ Date:_____

Have you had any prior surgical procedure of any kind? Y or N If yes, please explain

_____

_____

The following items can interfere with MR imaging and some may be hazardous.
Please check the appropriate box for each item

Yes	No		Yes	No	
[ ]	[ ]	History of metal particles in eyes?	Bone plates, rods or screws/artificial joints		
[ ]	[ ]	Any work experience as machinist/ boilermaker	[ ]	[ ]	Telemetry monitoring pack
[ ]	[ ]	Any chance of pregnancy	[ ]	[ ]	Cardiac stent/filter/coil in any
[ ]	[ ]	blood vessel Cardiac pacemaker/AICD/Defibrillator	[ ]	[ ]	Venous umbrella (Greenfield) Brain
[ ]	[ ]	aneurysm clip	[ ]	[ ]	Embolization coil
[ ]	[ ]	Dental implant held by a magnet]	[ ]	[ ]	Shunt- Type:
[ ]	[ ]	Mechanical heart valve	[ ]	[ ]	Eye implant
[ ]	[ ]	Implanted medicine pump/insulin	[ ]	[ ]	IUD/diaphragm/pessary ring
[ ]	[ ]	Nuerostimulator (TENS) unit	[ ]	[ ]	Tattoos/permanent make-up
[ ]	[ ]	Inner ear implant	[ ]	[ ]	Bullets, BBS, shrapnel
[ ]	[ ]	Prosthesis/penile implant	[ ]	[ ]	Medication patch
[ ]	[ ]	(nicotine/nitroglycerine)	[ ]	[ ]	
[ ]	[ ]	Surgical clips, staples, wires	[ ]	[ ]	

I have had the opportunity to ask any questions and they have been answered fully to my satisfaction. I attest that the above information is true to the best of my knowledge.

Signature:_____

Reviewed by:_____

Name _____ Date_____

Signature _____

Updated 11/2023