Nursing

Pacemaker or defibrillator ☐ Yes ☐ No	Aneurysm clips ☐ Yes ☐ No
Coils/ Filters or Stents within 8 weeks ☐ Yes ☐ No	Bone growth stimulator ☐ Yes ☐ No
Nerve Stimulator ☐ Yes ☐ No	Heart Valve Prosthesis ☐ Yes ☐ No
Cochlear (ear) implant ☐ Yes ☐ No	Insulin Pump ☐ Yes ☐ No
Pain Pump ☐ Yes ☐ No	Hearing Aids (if yes, please remove) ☐ Yes ☐ No
Metal in eye ☐ Yes ☐ No	Duraphase or Omniphase Penile Prosthesis ☐ Yes ☐ No
Shrapnel or Bullet ☐ Yes ☐ No	Tattoos or tattooed eyeliner ☐ Yes ☐ No
Diaphragm or IUD ☐ Yes ☐ No	Removable dental item ☐ Yes ☐ No
Transdermal (Skin) patch ☐ Yes ☐ No	Artificial Limb or Joint ☐ Yes ☐ No
Swan Ganz Catheter ☐ Yes ☐ No	Tissue Expander ☐ Yes ☐ No
	Does patient have ART Line ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No	Does patient have IV access ☐ Yes ☐ No
On Dialysis ☐ Yes ☐ No	Is the patient on oxygen ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No	Will the patient be able to lie flat & still for exam ☐ Yes ☐ No
Liver or Kidney Transplant ☐ Yes ☐ No	Is the patient claustrophobic ☐ Yes ☐ No
History of hypertension or high blood pressure ☐ Yes ☐ No	Does patient require sedation pre MRI ☐ Yes ☐ No
Pregnant ☐ Yes ☐ No	Patient Weight______lbs or _______kg
	Mode of Transport ☐ Stretcher ☐ Wheelchair

Does the patient have any type of artificial implant not mentioned above ☐ Yes ☐ No

If so, please list it here:____________________________

Reason for MRI:____________________________

History of surgery on the area being scanned today? ☐ Yes ☐ No

If patient had a previous MRI, please list facility it was performed :________________

Any history of cancer? ☐ Yes ☐ No

If so, please list here:____________________________

Has patient had any prior reaction to contrast? ☐ Yes ☐ No

Please list other allergies:____________________________

Nursing