DEPARTMENT OF RADIOLOGY
Dartmouth-Hitchcock
MEDICAL CENTER

MRI Safety and Scheduling Questionnaire

MRN:

NAME: two identifiers needed or patient label

DOB:

Date: ______________________ Patient's Weight: ______________________ Patient's Age: __________________

Question	Yes	No
Do you have a spinal cord stimulator?	Yes	No
Do you have a defibrillator?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have a deep brain stimulator?	Yes	No
Do you have retained cardiac leads from a pacemaker or defibrillator?	Yes	No

Question	Yes	No
Do you have a cerebral aneurysm clip?	Yes	No
Do you have a cochlear/other ear implant?	Yes	No
Do you have a vagus nerve stimulator?	Yes	No
Do you have an internal loop recorder (ILR)?	Yes	No
Do you have any other implanted devices or metal hardware including breast expanders, pins, plates, screws, rods, wire, etc.?	Yes	No

If yes to any of the above questions, please indicate make and model #: ______________________________________

Question	Yes	No
Have you ever worked with metal or have metal fragments in your eyes?	Yes	No
Have you been injured by a metal object e.g. shrapnel, bullet, BB gun?	Yes	No
Have you had a prior reaction to the injection of MRI IV contrast? If Yes, please describe__________________________ _	Yes	No
Do you have or are you being treated for diabetes? (patient ≥ 50 years)*	Yes	No
Do you have a history of kidney failure?*	Yes	No
Are you 70 years old or older?	Yes	No
Are you on dialysis?	Yes	No
Are you claustrophobic?	Yes	No
Have you ever required sedation or Anesthesia for an MRI? If Yes, please select one: ___Oral ___ IV ___ Anesthesia	Yes	No
Are you wearing any monitors or pumps on your skin? (If Yes, please remove before scanning)	Yes	No

Question	Yes	No
Are you wearing a Medication Patch (for pain medication/smoking cessation/etc.)?	Yes	No
Do you have any internal electrodes or wires?	Yes	No
Do you have dentures?	Yes	No
Do you have a hearing aid or other hearing devices?	Yes	No
Do you have braces?	Yes	No
Do you have any tattoos, permanent makeup, body/ dermal piercings, or body modifications?		
Are you wearing eyeliner, nail polish or metallic eyelash extensions?	Yes	No

If scanning an extremity, which side, do you usually experience your symptoms? ______________________________

Do you have any additional comments?

***For YES answer to these questions, a creatinine within 90 days of the scheduled exam is needed.**
Most recent creatinine on file:______________________
Date of creatinine:_______________________________

Continue to next page

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Question		
Do you have a Mediport?	Yes	No
Do you ambulate (walk) without assistance?	Yes	No
Do you have difficulty breathing or pain while lying flat?	Yes	No
Do you have mobility concerns? If yes, please describe: ______________________________________	Yes	No
Are you coming from a skilled care facility? If yes, you must be accompanied by a caregiver for the entire exam or transportation arrangements made be made in advance.	Yes	No
Does the patient require sedation? If Yes, what type? ____________________________________		
Does the patient require anesthesia?	Yes	No

Breast MRI Only

Bra Cup Size: _______ LMP: _______ Current BCT/ HRT: ____ Yes ____ No

Last mammogram date: _____________ Last mammogram location: ____________________

Form Completed By: ____ Date: ____________________________