NMC Northwestern Medical Center

Patient Name: _____ **DOB:** ____/_____/_____

MRI Patient Safety Screening Consent Form

Date: ____/_____/_____ Exam: _____

Symptoms/History: _____

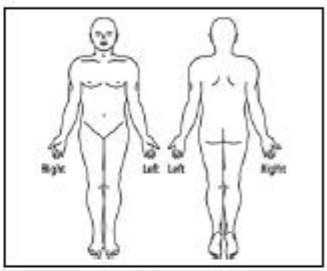
_____

Contrast: ☐ W/O ☐ W/ ☐ W/WO ☐ W (Arthrogram)

Laterality: ☐ Right ☐ Left ☐ Bilateral

Claustrophobic: ☐ No ☐ Yes ☐ Needs Medication

Height: _____ Weight: _____



Does the patient have any of the following	Yes	No	More Information
Previous surgery on region of interest			
Any Procedures/Surgery in the last 6 weeks?			
Any Cardiac Surgery			
Pacemaker/ Recorder or Cardiac Devices			
Any Head/Brain Surgery			
Aneurysm Clips, Coils, Filters			
Any Implanted Stents			
Electronic, Magnetic Devices, or Shunts			
Eye, Cochlear or Otologic Implants			
Implanted/Pumps/Stimulators/Wires/Batteries			
Implanted tissue expander			
Surgically implanted devices			
Vascular access port and or catheter			
Surgically implanted metal (Surgical clips, wires, staples, pins or plates			
History of Cancer			
Metallic foreign bodies in eyes or body			*Where? If yes removed or cleared by x-ray?*
Braces, splints, prosthetic limbs			
Medication patches or Body Piercings			
Possibility of pregnancy or Pregnant			

* R A D M *