Name MRN (Patient Identification)	VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298 **MRI Safety Checklist**

1. Have you had an MRI? .... No ___ Yes ___
   Did you have any difficulty related to the procedure? .... No ___ Yes ___
   If yes, please describe: ____________________
2. Do you have or have you had a pacemaker, ICD or defibrillator? .... No ___ Yes ___
3. Have you ever worked with grinding metals or had metal fragments in your eyes? .... No ___ Yes ___
4. Have you ever had a reaction or ill effect from MRI contrast material (**gadolinium**)? .... No ___ Yes ___
   If yes, please describe: ____________________
5. Do you have medicine or food allergies? .... No ___ Yes ___
   If yes, please describe: ____________________
6. Do you have sickle cell disease? .... No ___ Yes ___
   If yes, are you in sickle cell crisis? .... No ___ Yes ___
7. Do you have kidney (renal) problems or a kidney transplant? .... No ___ Yes ___
8. Have you been told your kidneys are not working properly? .... No ___ Yes ___
9. Are you on kidney dialysis? .... No ___ Yes ___
10. Do you have diabetes (high blood sugar)? .... No ___ Yes ___
11. **Female Patients Only:** Is there a possibility that you might be pregnant? .... No ___ Yes ___
    Are you currently breastfeeding? .... No ___ Yes ___

WARNING: Certain implants, devices, or objects may be hazardous to you and/or interfere with MRI studies. Do not enter the MRI area if you have any questions regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MRI room.
The MRI magnet is ALWAYS on.

Do you have or have you had? (Circle No or Yes)		Describe:
Aneurysm clips, coil or graft	No / Yes	____________________
Vascular stent, coil, clips or clamps	No / Yes	____________________
Cardiovascular catheter / Swan-Ganz catheter	No / Yes	____________________
Heart valve replacement	No / Yes	____________________
Implanted filter (i.e. Inferior Vena Cava filter)	No / Yes	____________________
Brain surgery clips	No / Yes	____________________
Implanted stimulator (i.e. vagal nerve, deep brain, TENS, bone growth)	No / Yes	____________________
Implanted infusion pump, catheter or device	No / Yes	____________________
Programmable shunt or VP shunt	No / Yes	____________________
Magnetically-activated implant or device	No / Yes	____________________
Internal or external monitoring devices (incl. temp or oxygen probes)	No / Yes	____________________
Epidural or nerve block catheter	No / Yes	____________________
Stapes prosthesis, cochlear implant	No / Yes	____________________
Eye prosthesis, lens implant, eyelid spring or wire, retinal tack	No / Yes	____________________
Internal electrodes or wires	No / Yes	____________________
Medication patch (nitroglycerine, nicotine, hormones, other medication)	No / Yes	____________________
Antimicrobial wound or burn dressing	No / Yes	____________________
Ingested camera pill for capsule endoscopy	No / Yes	____________________

please continue on next page

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Do you have or have you had? (Circle No or Yes) **Describe:**

Dental implant, dentures or partial plates... No / Yes ________________________
Intrauterine Device (IUD)... No / Yes ________________________
Penile implant.. No / Yes ________________________
Bullet or metallic fragments.. No / Yes ________________________
Tissue expander (i.e. breast expander).. No / Yes ________________________
Permanent make-up, tattoo, piercing... No / Yes ________________________
Hearing aid (remove before entering the MRI room)........................... No / Yes ________________________
Artificial or prosthetic limb.. No / Yes ________________________
Joint replacement or resurfacing .... No / Yes ________________________
Any other type of device, implant or prosthesis not listed above: ____

____

List all operations you have had: ____
____
____

Weight: ___________ Height: _____________

I have answered these questions to the best of my ability and I understand that possible injury could result if I withhold vital information.

Signature: ________________________________ Relationship to patient: ________________
(Patient, guardian, or designee)

Inpatients Only: Nurse or MD responsible for reviewing form's completeness and accuracy:

__________________________ __________________________ Date:________ Time: ________
Printed Name (RN, MD) Signature (RN, MD)

Radiology verification of form accuracy and patient safety review:

______________________________ __________________________ Date:________ Time: ________
Printed Name (Technologist/Radiologist) Signature (Technologist/Radiologist)

For staff use only below this line

If renal problems, diabetes, or age >65, blood work should be within 30 days for IV contrast.

eGFR *(estimated Glomerular Filtration Rate)*_______________ Creatinine __________________

Date of result: ______________________________________ Source: ____ POCT ____ Lab

If GFR < 60 or yes to renal problems / transplant / dialysis and contrast is required, was the information sheet regarding gadolinium given to the patient? **Yes / No**

Tech initials__________ If no, explain____

Gadolinium given: Yes ___ No___ CONTRAST: ________________________________ VOLUME: ____________mL

Approving Radiologist if eGFR < 30: ____

TECHNOLOGIST: __________________________ ___________________________ ____________ ______________
Printed Name Signature Date Time