Dartmouth Health

MRI Safety and Scheduling Questionnaire

MRN:

NAME: two identifiers needed or patient label

DOB:

Date: _____Patient's Weight (lbs.): _____Patient's Height (ft/in): _____

Can you walk without assistance, including walking without a cane/walker? (If no, list what assistive device is needed.)	Yes	No
Are you claustrophobic?	Yes	No
Have you ever required sedation or anesthesia for an MRI Exam?	Yes	No
If the patient needs an interpreter, enter language:		
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
Do you have a Mediport or other active implanted port that you would like to use?	Yes	No
Have you ever had a prior reaction to the injection of MRI IV Contrast? (Include type of reaction)		
Do you have braces and/or dental expanders?	Yes	No
Do you have a Pacemaker and/or Defibrillator? (If yes, exam can only be performed at Lebanon and Cheshire locations. Please document make and model)	Yes	No
Do you have any abandoned cardiac or stimulator leads/electrodes?	Yes	No
Do you have any implanted Stimulator? (Deep Brain Stimulator, Spinal Cord Stimulator, Vagal Nerve Stimulator, Bladder Stimulator, or any other stimulator. If yes document make and model #)	Yes	No
Do you have a Cerebral Aneurysm Clip? (Please document make, model, year implanted, and what hospital it was placed)	Yes	No
Do you have a Cochlear and/or other ear implants? (Please document make and model)	Yes	No
Are you wearing any medication patches, monitors (including continuous glucose monitors), or pumps on your skin? (If yes, these will need to be removed for the MRI exam, so please plan accordingly)	Yes	No
Do you have any breast tissue expanders and/or breast implants?	Yes	No
Have you ever had metal fragments in your eyes? (If yes, has it been completely removed by an ophthalmologist. If no or uncertain, will need Pre-MRI orbital x-rays unless a recent x-ray or CT is available).	Yes	No

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Have you been injured by a metal object such as shrapnel, bullets, bb's? (Please document year, type of metal object, and location in body). Any prior imaging (e.g., x-rays) of the area involved?	Yes	No
Do you have any other implanted devices or metal hardware including stents, grafts, pins, plates, screws, rods, wires, etc.? (Please document type of implant and location in body)	Yes	No
Do you have any tattoos, permanent makeup, body/dermal piercings or body modifications? (Any recent tattoos in last 2 weeks?)	Yes	No
Do you have dentures/hearing aids? (If yes, these will need to be removed prior to getting the actual MRI)	Yes	No
Are you wearing any jewelry, hair extensions, magnetic eye lashes, etc.? (If yes, these should be removed and not brought to your MRI appointment)	Yes	No
Are you pregnant and/or breast feeding?	Yes	No
If scanning an extremity, which side, do you usually experience your symptoms?	Left	Right

Breast MRI Only

Bra Cup Size: _____LMP: _____Current BCT/ HRT: _____Yes _____No

When is your next expected menstrual period?: _____

Last mammogram date: _____Last mammogram location: _____

Form Completed By: _____Date: _____