Jupiter Medical Center
Jupiter, FL. 33458

SAFETY SCREENING FORM FOR MRI PROCEDURES

Name____________________________________ Date____________________
Physician_________________________________ Weight__________________
Reason for exam ____
____
____

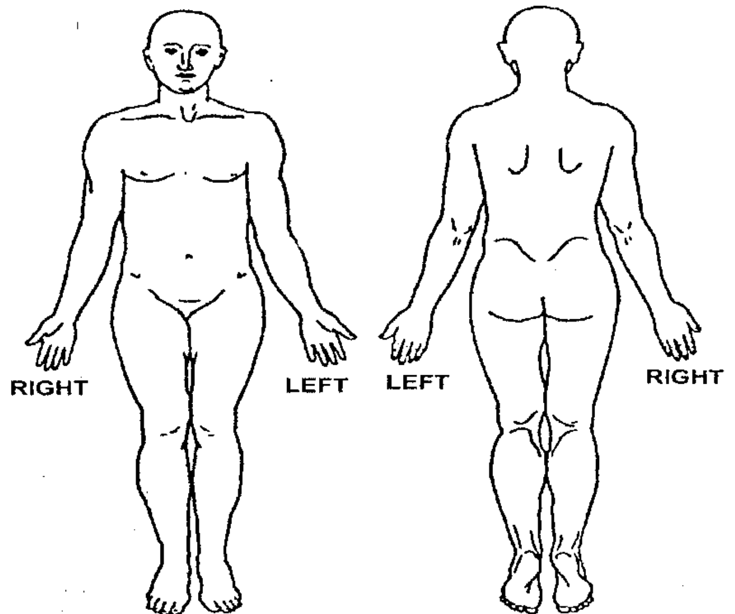
Have you ever had an injury from a metal object in your eye (metal slivers, metal shavings), or other metal objects?_________
If yes, did you seek medical attention? ______
Do you have any drug allergies? __________
If yes, please list drugs____
Are you pregnant or suspect you may be pregnant? _______
Are you breast feeding? ________
Are you claustrophobic? _______

MRI HAZARD CHECKLIST

The following items may be harmful to you during your MRI exam or may interfere with an MRI exam. You must provide a yes or no for every item.

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.

	Yes	No
Cardiac pacemaker	___	___
Aneurysm clip	___	___
Implantable cardiac stimulator	___	___
Neurostimulator	___	___
Biostimulator	___	___
Any type of internal electrodes or wires?	___	___
Any type of electronic, mechanical or magnetic implant (please circle)	___	___
Cochlear implant	___	___
Hearing aid	___	___
Implanted drug pump (insulin, chemotherapy or pain)	___	___
Any type of coil, filter or stent?	___	___
Any type of metal (bullet, shrapnel, BB)	___	___
Recent surgery with metal sutures?	___	___
Penile implant or IUD?	___	___
Nitro or pain patch?	___	___



Form # jmc7513