

**MOHAWK VALLEY MRI**  
**@Amsterdam Memorial Hospital**  
**MRI SAFETY SCREENING FORM**

Date: \_\_\_\_\_

Name (first middle last): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Sex (please circle): Male Female

Have you ever had an MRI? Yes No

If yes, please list when, where, and what body part:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Body part having MRI today: \_\_\_\_\_

Was it an injury? Yes No

Please explain the reason for the exam and any symptoms you are having: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any prior surgery to the body part being imaged today? Yes No

If yes, what was the surgery? \_\_\_\_\_

Have you had previous imaging related to this injury/illness? Yes No

If yes please circle what type and where it was done:

X-ray \_\_\_\_\_  
Cat Scan (CT) \_\_\_\_\_  
MRI \_\_\_\_\_  
Ultrasound \_\_\_\_\_

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

Please circle Yes or No if you have any of the following:

Yes	No	Do you carry a card indicating that you have an implant or medical condition of any kind? If yes, please present the card to the receptionist
Yes	No	CARDIAC PACEMAKER
Yes	No	Aortic clips
Yes	No	Brain Vessel Clips
Yes	No	Coronary artery or heart surgery of any type If yes when: _____
Yes	No	Cochlear Implants (date put in: _____ Brand: _____ Model#: _____)
Yes	No	Stents (date put in: _____ Brand: _____ Model#: _____)
Yes	No	Artificial heart valve (date put in: _____ Brand: _____ Model# : _____)
Yes	No	Insulin Pump, TENS unit or pain stimulating pump
Yes	No	Electrodes
Yes	No	Metal plates, pins, screws, nails, clips, shrapnel or fragments
Yes	No	Joint replacements / prosthesis (If yes, Where in body? _____)
Yes	No	Body piercing (please remove prior to your scan)
Yes	No	Tattoos of any kind (cosmetic or decorative) If yes, how old is the most recent tattoo: _____
Yes	No	Medication patches
Yes	No	Hearing aides (please remove prior to entering the scanning room)
Yes	No	Dentures or partial plates
Yes	No	Have you ever worked with sheet metal, as a metal worker, grinder, or welder?
Yes	No	History of kidney failure or poor kidney function
Yes	No	Have you been or are you currently on dialysis?
Yes	No	History of cancer (If yes, please specify where: _____)
Yes	No	Hypertension
Yes	No	Diabetes
Yes	No	Claustrophobic
Yes	No	Asthma
For female patients:		
Yes	No	Are you pregnant or experiencing a late menstrual period?
Yes	No	Are you currently breast feeding?

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I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Signature of Technologist: \_\_\_\_\_ Date: \_\_\_\_\_