UNIVERSITY Imaging
St Joseph's Wayne Hospital

MRI - Patient Information

Date:_____ Date of Birth: _____

Name:_____ Weight(lbs): _____

Have you ever worked in a machine shop or similar environment where you have been subjected to small metal slivers, particularly in the eyes? (please circle) YES NO
Previous MR study? (please circle) YES NO
Date of Type of MRI study: _____

Have you ever had surgery other than dental surgery? (please circle) YES NO
Date and Type of surgery:
Head and Neck _____
Chest and Abdomen _____
Extremities _____

The following items can interfere with MR imaging and some can actually be hazardous to your safety. Please check if you had any of these items:

Yes___ No ___ Cardiac pacemaker or pacemaker lead wires
Yes___ No ___ Brain aneurysm clips
Yes___ No ___ **Linx Device**
Yes___ No ___ Artificial heart valve
Yes___ No ___ Aortic clips
Yes___ No ___ Implanted neurostimulators or lead wires
Yes___ No ___ Insulin pump
Yes___ No ___ Electrodes
Yes___ No ___ Hearing aids or cochlear implants
Yes___ No ___ IUD
Yes___ No ___ Joint replacements
Yes___ No ___ Shunts
Yes___ No ___ Metal rods, pins, screws, metal mesh or wire sutures
Yes___ No ___ Shrapnel
Yes___ No ___ Tattoo
Yes___ No ___ Others _____

Do not enter the scan room with any metal or magnetic sensitive items.
Check items below if you have any of the following:

____ Jewelry ____ Removable dental works ____ Hearing aid
____ Pens ____ Wallet or Money clip ____ Watch / Glasses
____ Safety pins or hair pins ____ Keys or coins
____ Magnetic strip cards ____ Pocket knife

Type of MRI examination you are having today: _____

Any injury to the area? YES ____ NO ____ if yes, date of injury _____

Explain the reason for the MR: _____

Any particular disease you or your physician would like to rule out? _____