St Joseph's Healthcare System
St. Joseph's Regional Medical Center
St. Joseph's Wayne Hospital
A Division of St. Joseph's Regional Medical Center
St. Vincent's Nursing Home

Name: _____

D.O.B.: _____

MR # : _____

OR PLACE STICKER HERE

DEPARTMENT OF RADIOLOGY
MRI SAFETY QUESTIONNAIRE

Please complete the entire form: check each appropriate box. All questions must be answered. Upon completion: sign, date, and fax form to MRI Department at x2623.

YES	NO		YES	NO	
☐	☐	Cardiac pacemaker	☐	☐	Radiation Seeds
☐	☐	Implanted pacing wires	☐	☐	Transdermal Medication Patch
☐	☐	Defibrillator (ICD)	☐	☐	Wound Dressing Containing Metal (Ag)
☐	☐	Intracranial Aneurysm Clips			Type: _____
☐	☐	Aneurysm Repair Surgery	☐	☐	Tattoo or permanent make-up
☐	☐	Neuro/Spinal Cord Stimulator (TENS Unit)	☐	☐	Body Piercing Jewerly
☐	☐	Drug Infusion Pump	☐	☐	Any Electronic Implanted Device
☐	☐	Intravascular Stent			Type: _____ Date Implanted: _____
		Type: _____ Date Implanted: _____	☐	☐	Any type of prosthesis (Eye, Penile, etc.)
☐	☐	Intravascular Coil / filter			Type: _____ Date Implanted: _____
		Type: _____ Date Implanted: _____	☐	☐	Metal Worker (Grinding, Welding, etc.)
☐	☐	Heart Valve	☐	☐	Bullets or Shrapnel
		Type: _____ Date Implanted: _____	☐	☐	Joint Replacement
		Make: _____ Model: _____			Type: _____ Date Implanted: _____
☐	☐	VP / Spinal Shunt	☐	☐	Hearing Aid
☐	☐	Ocular Implants / Retinal Tack	☐	☐	Dental implant; ☐ Crown, ☐ Caps, or ☐ Bridge
☐	☐	Eyelid Spring or wire	☐	☐	Removable Dentures
☐	☐	Cochlear, Otologic or other ear implant	☐	☐	Dialysis ☐ Hemo or ☐ Peritineal (check one)
☐	☐	Thermodilution Catheter (Foley, NG)	☐	☐	Sickle Cell Anemia
		Type: _____	☐	☐	Pregnant
☐	☐	Vidacare EZ-IO device	☐	☐	Breast Feeding
☐	☐	Pill Cam Examination			
☐	☐	Tissue Expander			
☐	☐	Mastectomy ☐ Left ☐ Right			
☐	☐	Pessary device			

Please describe symptoms here:

_____

_____

Info obtained from: ☐ Patient ☐ Family Member ☐ Chart ☐ Other _____

---------- For In-Patient Only ----------

YES	NO	
☐	☐	Is the patient awake, alert and oriented?
☐	☐	Is the patient able to hold still for the exam?
☐	☐	Is pre-medication ordered for the Patient?
☐	☐	Isolation Precaution Type: ☐ Resp. ☐ Contact ☐ Droplet
☐	☐	Is the Patient vented?
☐	☐	Is the Patient on a medication pump?
☐	☐	Does the patient have IV Access

Patient weight: _____ lbs.
eGFR: _____

Please have patient remove all jewelry, watches, and hair pins before coming to MRI Department.

Name of person completing form:

_____ / _____	_____	_____	_____
Print Name / Signature	Relationship if other than patient	Date	Time

Healthcare Provider: _____ _____ _____
Signature Date Time

Form Reviewed in MRI By: _____ _____ _____
Signature Date Time

For MRI Use Only: Ear Protection Provided: ☐ YES ☐ NO Initials: _____