

**Magnetic Resonance Imaging Contraindications**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

To ensure your safety, and the most accurate results, please answer the following questions as carefully as possible, please check all that pertain to you.

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 Post-scheduling Contraindications

 Shrapnel

 Metal worker

 History of Renal (kidney) Failure

 History of Seizures

 Tattooed eyeliner

 Hearing Aid

 Implanted pumps, magnets or ports

 Dentures

 Transdermal Patch (Skin Medication Patch)

 Pre-scheduling Contraindications

 Pacemaker or Defibrillator

 Brain surgery

 Ear surgery

 Eye surgery (Including EYE prosthesis)

 Heart surgery

 Previous back surgery (Including Neurostimulator)

 Claustrophobia

 Breast feeding

 Pregnancy or suspected pregnancy

 Recent surgery

Patient's approx. weight \_\_\_\_\_\_\_\_\_\_\_

Patient's approx. height \_\_\_\_\_\_\_\_\_\_\_

Patient’s Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interviewers Initials: \_\_\_\_\_\_\_\_\_\_

Notes:

Technologist’s Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_