Icahn School of Medicine at Mount Sinai — *Translational and Molecular Imaging Institute*

Name: _____

Date of Birth: ____/____/____ Insurance Gender: _____ Gender Identity: _____

Requesting Physician/Principal Investigator: _____

Today's Date: ____/____/____

Med Rec Num: _____ (if known) Accession: _____ (if known)

MAGNETIC RESONANCE IMAGING (MRI) SUBJECT SCREENING QUESTIONNAIRE

INSTRUCTIONS: Please respond to items 1-22 below. This information will allow us to determine your eligibility for an MRI scan. Each box should be marked **individually**--please do not simply draw a line down a column.

	YES	NO	Tech inits each positive response
1. Do you have a **pacemaker**, **AICD,** internal **pacing wires, EKG leads** or **Holter monitor**?	☐	☐	1
2. Do you have an implanted **stimulator** (including **bone growth stimulator, spinal stimulator** or **cochlear or other ear implant**) or **medication infusion pump**?	☐	☐	2
STOP **"YES"** response to either question above requires **discussion with Radiology technologist or physician** before proceeding. STOP			
3. Have you had **brain surgery** or do you have **metallic clips (aneurysm clips)** in your head?	☐	☐	3
4. Have you ever had eye surgery or implants?	☐	☐	4
5. Have you ever worked around a **metal lathe**, had **metal shavings** or **fragments** in your eye(s), or had a **shrapnel** (war or gunshot) injury anywhere in your body?	☐	☐	5
6. Have any devices (e.g., **stent, filter, coil** or **vascular port/catheter**) been placed in your blood vessels?	☐	☐	6
7. Do you have an implanted **tissue expander**?	☐	☐	7
8. Do you have a **replaced heart valve**, other **prosthesis** or any other **surgical implant**?	☐	☐	8
9. List **any other** type of metal in or on your body: _____			9
10. Do you have a history of **rectal surgery or severe hemorrhoids**? (For patients with pelvic or prostate scans)	☐	☐	10
11. Do you have any **tattoos**, **permanent make-up**, or **piercings**?	☐	☐	11
12. Do you wear **hearing aid(s),** either in the ear canal or on the surface? *(**MUST BE REMOVED** before entering room)*	☐	☐	12
13. Do you wear a transdermal **medication patch** (e.g., Nitroglycerin, Nicotine, etc.)?	☐	☐	13
14. Do you have **kidney/renal** disease, **liver** disease, or **diabetes**?	☐	☐	14
15. Do you have any **allergies**? If so, specify: _____	☐	☐	15
16. Are you **claustrophobic** (afraid of enclosed or tight spaces)?	☐	☐	16
17. Are you wearing a **RFID** or Radiofrequency ID device (commonly a wristband on an inpatient)?	☐	☐	17
18. If female, are you (or could you be) **pregnant** or are you **breastfeeding**?	☐	☐	18
19. For **gadolinium contrast** ("dye") exams**,** please confirm you have had an opportunity to **read the medication guidelines** (on the back or on a second page):	☐	☐	
20. Subject **age**: _____ years			
21. Approximate subject **weight**: _____ (pounds) and **height**: _____ (feet-inches)			
22. Print & sign your name, and indicate date, time & relation to subject:			

PRINTED NAME

x _____
SIGNATURE

____/____/____ ____:____ am pm ☐ Subject ☐ Physician ☐ Relative ☐ Other:
DATE TIME

WARNING: THE MRI MAGNET IS ALWAYS ON!
Do not enter the MRI scanner room or the MRI environment if you have any question or concern regarding an implant, device or object. Consult the MRI technologist or radiologist BEFORE entering an MRI room.

FOR SUBJECTS REQUIRING ASSISTANCE WITH QUESTIONNAIRE

☐ **Information corroborated by chart history (required)**

NAME OF INDIVIDUAL ASSISTING ____/____/____ DATE

SIGNATURE ☐ RN ☐ MD ☐ Other: ____:____ am pm TIME

MRI EMPLOYEE REVIEWING MRI SAFETY RESPONSES

☐ **Checklist reviewed and any positive responses addressed/reconciled (required)**

NAME OF INDIVIDUAL ASSISTING ____/____/____ DATE

SIGNATURE ☐ RT ☐ MD ☐ Other: ____:____ am pm TIME

CONTRAST SCREENING (FOR GADOLINIUM PATIENTS)

☐ **CHECK if drawn as Point-of-Care Test in Radiology**

DRAWN	REVIEWED	RESULTS	SCREENING (q 14, 15, 18) AND LAB RESULTS REVIEWED BY:
____/____/____ ____:____ am pm	____/____/____ ____:____ am pm	eGFR (mL/min/1.73 m²) ____ Non-AA ____ AA; Cr (mg/dL) ____	RN INITIALS

GADOLINIUM INJECTION RECORD

CONTRAST AGENT	SITE	VOLUME	RATE
		mL	mL/s

OUTCOME: ☐ Routine Injection ☐ Contrast Reaction ☐ Extravasation ☐ Other Event } See electronic / supplementary documentation for details

INJECTING PERSONNEL

PRINTED NAME _____ SIGNATURE _____ TITLE _____ ____/____/____ DATE ____:____ am pm TIME