Princeton Radiology
Excellence in Imaging

MRI SCREENING FORM

NAME: _____ D.O.B:___/___/___ AGE: ____ SEX: M / F
(Last) (First)

WT: ____lbs HT: ___ft. ___in. REFERRING PHYSICIAN: _____

Have you ever worked with metal or had an injury to your eyes involving metal?	Yes	No
Are you a welder, machinist or do you weld or grind metal?	Yes	No
Do you have any mechanical, shrapnel or other metallic foreign object implanted in your body?	Yes	No
Are you on dialysis?	Yes	No

Do you have, or have you ever had, any of the following: (If yes, circle)

PACEMAKER/WIRES/DEFIBRILLATOR
IUD
SHRAPNEL (bomb or bullet fragments)
COCHLEAR IMPLANTS
BODY PIERCING
NEURO/BONE/BLADDER STIMULATOR
TATTOOS (over 20 years old)
PESSARY (bladder support)
STENTS/SHUNTS
ENDOSCOPY CLIPS
BRACES
ORTHOPEDIC HARDWARE
ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy)
MEDICATION PATCH (birth control/nicotine/Nitroglycerine)
METAL SLIVERS IN EYES
DIABETES or KIDNEY DISEASE
HEARING AIDS
BREAST TISSUE EXPANDER
HEART VALVE REPLACEMENT
PENILE IMPLANT
TATTOOED EYELINER
ANEURYSM CLIPS
REMOVABLE DENTAL WORK/DENTURES
INGESTED PILL CAMERA/PH BRAVO CAPSULE
HISTORY OF EAR TUBES/IMPLANTS

I acknowledge that all the information given is accurate.
I do not have a pacemaker.
I have removed all hearing aids, dentures, any external pumps and monitoring devices.

_____ Date: _____ Technologist Initials: _____
Patient's Signature