



BREAST MRI PATIENT HISTORY AND SCREENING

Patient Name _____ DOB _____ Weight _____

The following items can cause harm to you as a patient in the MRI scanner. Please check the following as it applies. Please be as accurate as possible. The FDA has not established any criteria under which a pregnant woman may be scanned. Therefore, it is the policy of this facility that MR imaging NOT be routinely performed on a woman known or suspected to be pregnant.

Have you ever had an MRI before? If yes please list _____

| Are you or do you have any of the following? | Yes | No | Not Sure |
|---|-----|----|----------|
| Are you pregnant or breastfeeding | | | |
| IUD, diaphragm or pessary | | | |
| Pacemaker or Defibrillator | | | |
| Pain or Infusion pump | | | |
| Body piercing (including ears) | | | |
| Hearing aid(s) | | | |
| Artificial Limbs | | | |
| Coronary Stent or bypass clips | | | |
| Vena Cava Filter | | | |
| Permanent eyeliner / tattoos | | | |
| Cochlear (ear) Implant | | | |
| Brain Aneurysm Clips | | | |
| Neurostimulator (Tens Unit) | | | |
| Claustrophobia | | | |
| Shrapnel or Bullets | | | |
| Could you ever had metal in your eyes | | | |
| Have you ever had metal removed from your eye | | | |

Have you ever had brain surgery? _____

List any other metal in your body _____

Brief explanation for your visit _____

Please remove all metallic objects before entering the MRI including keys, hairpins, barrettes, jewelry, watch, safety pins, paper clips, money clips, credit cards, coins, wallet, belt, metal buttons, pocket knife and clothing with metal in the material. Please note you will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible hazard related to acoustic noise. Please consult the MRI Technologist if you have questions or concerns BEFORE you enter the MR Suite.

I have read and understood and hereby consent to this MRI examination.

Patient Signature _____ **Date:** _____

I have reviewed and discussed these safety items with the above signed patient or guardian and approve this patient for magnetic resonance imaging.

Technologist Signature: _____ **Date:** _____