



ARTHROGRAM MRI Screening Questionnaire

WARNING: The MRI magnet is ALWAYS on. Do not enter the MRI system room or MRI environment if you have a metal, implant, device or object on or in your body. **Never enter the MRI room until you have consulted with the MRI Technologist.** Before entering the MRI room, you should remove all metallic objects, including hearing aids, hair pins, barrettes, jewelry, body piercing jewelry, cell phone, beepers, watches, and all items from your pockets. Billfolds and purses should not be taken into the MRI room. You may be asked to put on a gown, and you are required to wear earplugs or some other hearing protection. **You will still need to wear a mask during MRI.**

Patient Name: _____ **Date of Birth:** _____ **Weight:** _____

The following items may interfere with MRI Imaging. Do you have any of the following?
Please **CIRCLE "Y"** (for **YES**) or **"N"** (for **NO**) on **EACH** individual question.

Y / N Cardiac pacemaker/Defibrillator	Y / N Allergy to x-ray dye, iodine?
Y / N Coumadin or Plavix regimen, or Blood thinner	Y / N Allergy to latex?
Y / N Currently taking antibiotics	Y / N Allergies: _____
Y / N Internal electrodes or wires	Y / N Shunt (spinal or ventricular)
Y / N Stents, filters, coils, artificial heart valve	Y / N Wire mesh implant
Y / N Brain clips, Aneurysm clips, Aortic clips	Y / N Port and/or catheter
Y / N Surgical staples, clips, metallic sutures	Y / N IUD (Effectiveness could be compromised)
Y / N Glucose monitor	Y / N Pregnant and/or breastfeeding
Y / N Medication patch	Y / N Prosthesis (eye, penile, etc.)
Y / N Drug, insulin, infusion pump	Y / N Tattoo and/or Permanent makeup
Y / N Electronic, mechanical, or magnetic implant	Y / N Non-removable body piercing/ jewelry
Y / N Prosthesis/ Joint replacement	Y / N Hearing aid (must remove for scan)
Y / N Cochlear/stapes implant in ear	Y / N Shrapnel, BB, or bullets
Y / N Tissue Expander (e.g. breast)	Y / N Dentures or partial plate
Y / N Bone/Joint plates, screws, pins, staples, rods	Y / N Dental Implants
Y / N Metal fragments or foreign body	Y / N Personal history of cancer
Y / N Claustrophobic (if medicated patient must have a driver)	Y / N Implanted Stimulator
Y / N Motion disorders (i.e., involuntary shaking, moving)	
Y / N Ever had metal in your eyes?	
If YES to metal in eyes, was it completely removed by a doctor (MD)? Y/N	

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form, and I have had the opportunity to ask questions regarding the information on this form.

Signature of Patient or Legal Guardian:	Date:
Signature of Pinnacle Witness:	Date:
Verified by MRI Technologist:	Date: