

Please indicate if you have any of the following:

- Yes No Aneurysm Clip(s)
 Yes No Cardiac pacemaker
 Yes No Implanted cardioverter defibrillator (ICD)
 Yes No Electronic implant or device
 Yes No Magnetically-activated implant or device
 Yes No Neurostimulation system
 Yes No Spinal cord stimulator
 Yes No Internal electrodes or wires
 Yes No Bone growth/bone fusion stimulator
 Yes No Cochlear, otologic, or other ear implant
 Yes No Insulin or other infusion pump
 Yes No Implanted drug infusion device
 Yes No Any type of prosthesis (eye, penile, etc.)
 Yes No Heart valve prosthesis
 Yes No Eyelid spring or wire
 Yes No Artificial or prosthetic limb
 Yes No Metallic stent, filter, or coil
 Yes No Shunt (spinal or intraventricular)
 Yes No Vascular access port and/or catheter
 Yes No Radiation seeds or implants
 Yes No Swan-Ganz or thermodilution catheter
 Yes No Medication patch (Nicotine, Nitroglycerine)
 Yes No Any metallic fragment or foreign body (bullets, BB's, pellets)
 Yes No Wire mesh implant
 Yes No Tissue expander (e.g., breasts)
 Yes No Surgical staples, clips, or metallic sutures
 Yes No Joint replacement (hip, knee, etc.)
 Yes No Bone/joint pin, screw, nail, wire, plate, etc..
 Yes No IUD, diaphragm, or pessary
 Yes No Dentures or partial plates
 Yes No Tattoo or permanent makeup
 Yes No Body piercing jewelry
 Yes No Hearing aid (*remove before entering MR system room*)
 Yes No Other implant _____
 Yes No Breathing problem or motion disorder
 Yes No Claustrophobia

**IMPORTANT
INSTRUCTIONS**

Before entering the MR environment, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beepers, cell phone, eyeglasses, hairpins, barrettes, jewelry, body piercings, watch, safety pins, money clip, credit cards, bank cards, coins, pens, nail clipper, tools, clothing with metal fasteners or metal thread.

NOTE: You are required to wear ear plugs during your exam

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of person completing form: _____ Date: ___/___/___

Form completed by: Patient Relative Nurse _____
Print name Relationship to patient

Form reviewed by: _____

Print name

signature