LUMINA
IMAGING AND DIAGNOSTICS

Name:

DOB:

Height: _______ **Weight:** _______

MRI Patient Safety Questionnaire

Please inform the MRI technologist of any implants in or on your person. You will be asked to change into MRI-safe attire and a locker will be made available for storage of your personal belongings. Please remove all accessories such as glasses, jewelry, piercings, hair accessories, wallets, watches, hearing aids, etc.

Body part to be examined: ____________________________________ Previous surgery on this body part: ___\ ___\ ___

List all previous surgeries: (e.g., arthroscopy, endoscopy, etc.) None

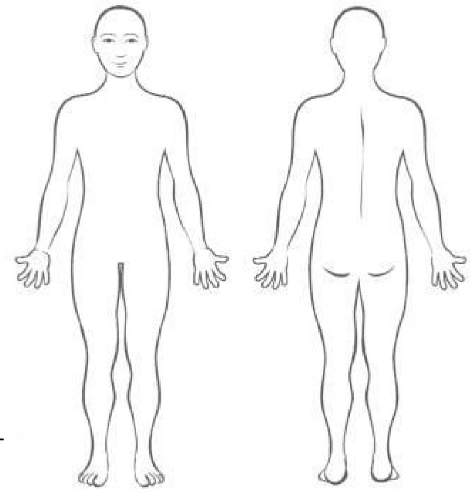
Type of Surgery:	Approximate Date:
__________________________	___\ ___\ ___
__________________________	___\ ___\ ___
__________________________	___\ ___\ ___

Yes No Have you had a colonoscopy, endoscopy or pill endoscopy within the last 6 months?
Yes No Have you had a previous reaction to MRI contrast?

Please indicate if you have any of the following:

Yes No Have you ever had an injury to the eye involving a metal object? (i.e. metallic slivers, shavings, etc.)
Yes No Brain Aneurysm Clip(s)
Yes No Cardiac pacemaker/defibrillator
Yes No Heart recording device (example: loop recorder)
Yes No Retained electrical leads, wires or electrodes
Yes No Neurostimulator, deep brain, nerve, spinal cord, bladder, and/or bone growth stimulator
Yes No Shunts Is it programmable? Yes No
Yes No Heart stent or heart valve
Yes No Stent, coil or filter other than heart
Yes No Implanted or worn drug infusion pump or other infusion pump (e.g. baclofen, chemotherapy, pain medicine)
Yes No Insulin pump
Yes No Medication patch and/or external monitoring patch
Yes No Any implanted magnetic, mechanical or electrical device
Yes No Any implant held in place by a magnet
Yes No Surgical clip or staple
Yes No Bullets, BBs or metal shrapnel
Yes No Any prosthesis (e.g. limb, eye, etc.)
Yes No Tissue expanders (example: breast)
Yes No Penile implant
Yes No Cochlear, otologic or other ear implant
Yes No Hearing aids (please remove)
Yes No Body piercing (please remove)
Yes No Removable dentures, false teeth or partials
Yes No Tattoos or permanent makeup Most recent: ___\ ___\ ___
Yes No Wig, hair extensions
Yes No Eyelid spring or wire
Yes No Diaphragm, IUD, pessary
Yes No Any chance of pregnancy Last menstrual period: ___\ ___\ ___
Yes No Breast feeding
Yes No History of diabetes
Yes No History of renal disease (solitary kidney, renal transplant, renal tumor)
Yes No History of hypertension
Yes No Any other implant not listed: _________________________

Please indicate location of implant or metal on or inside your body.



Signature of person completing form: ________________________________ **Date:** ___\ ___\ ___

Relationship to patient: ________________________________

Technologist initials _______