MRI SCREENING QUESTIONNAIRE:

PATIENT IDENTIFICATION

The following items may be harmful to you during your MR scan or may interfere with the MRI examination. Please check “Yes” or “No” to indicate whether you have or have had any of the following. Remove ALL metallic objects prior to MRI. Please provide any implant card.

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Pacemaker</td>
<td></td>
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<tr>
<td>Implanted Cardiac Defibrillator</td>
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<tr>
<td>Tissue Expanders (Breast or other)</td>
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If you responded “Yes” to any of the above, you may NOT be eligible for MRI. Please contact a representative in MRI at 314-362-1695 or talk to a representative at the reception desk.

Age | Weight | Height | Claustrophobic | Yes | No |
---  |------- |------- |---------------|-----|----|
Allergy to MRI Contrast           |     |       | Yes            |     |    |
Pregnant or Breastfeeding         |     |       | No             |     |    |
Kidney Disease/Dialysis           |     |       | No             |     |    |
Metal in Eye                      |     |       | Yes            |     |    |
Endoscopy Camera Pill             |     |       | No             |     |    |
Programmable Shunt                |     |       | Yes            |     |    |
Neurostimulator                   |     |       | No             |     |    |
Penile Implant                    |     |       | Yes            |     |    |
Coils, filters or stents          |     |       | No             |     |    |

If you responded “Yes” to any of the items below, for your safety, the items MUST be removed.

Hearing Aid                       |     |       | False Teeth or Partial Plate | Yes | No |
Medication Patch                  |     |       | Body Piercing | Yes | No |
Artificial Limb                   |     |       | Wig, Hair Implants, Clips or Pins | Yes | No |

LIST ALL SURGERIES: COMMENTS:

Person Completing Form: ___________________________ Date: ___________ Time: ___________

Form Completed By: □ Patient □ Clinician or RN

Printed Name Required

Date of Exam: ___________ Charge Technologist Signature: ___________________________ Time: ___________

MR Technologist Signature: ___________________________ Time: ___________