UHN Michener Institute of Education

MRI NON-PATIENT SAFETY SCREENING FORM

Student Name: _____

Student ID no.: _____

PURPOSE: The MR system is composed of a very strong magnetic field. The MR system magnet is ALWAYS on, and all metal objects must be removed prior to entering the MR system room. Certain implants, devices, or objects may be hazardous to you when entering the MR environment. Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. All individuals must be screened to determine eligibility to enter the restricted MR environment, including the examination room. If you had an incident of metal in their eyes will require an orbital x-rays may be required as part of the screening process. If you are pregnant during your clinical rotation, you must inform your clinical coordinator at your site.

Please answer the following questions:

☐ Yes ☐ No Have you EVER done metal work (i.e.: welding, grinding, cutting) as a hobby, profession, or at school?

If YES, please specify: _____

If YES, did you ALWAYS wear eye protection while working with metal: ☐ YES ☐ NO

☐ Yes ☐ No Have you EVER had metal fragments (e.g., metallic silvers, shavings, foreign bodies) in your eyes from any accidents, welding, grinding or cutting?

If YES, please specify: _____

☐ Yes ☐ No Have you EVER been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?

If YES, please specify: _____

☐ Yes ☐ No Have you EVER had any prior surgery/operation/invasive procedure (e.g., heart, brain, eye abdominal, orthopedic, etc. surgery)? *Listing surgeries can help identify potential unknown implants.*

If YES, please specify date and type of surgery: _____

_____

☐ Yes ☐ No Were implants inserted in your body as a result of the surgery/procedure(s)?

If YES, please specify:

- Implant name and/or type: _____
- Implant make and model (if available): _____

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Please indicate if you have any of the following:

YES	NO	
☐	☐	Aneurysm clip(s)
☐	☐	Cardiac pacemaker
☐	☐	Implanted cardioverter defibrillator (ICD)
☐	☐	Electronic implant or device
☐	☐	Magnetically-activated implant or device
☐	☐	Neurostimulation system
☐	☐	Spinal cord stimulator
☐	☐	Internal electrodes or wires
☐	☐	Bone growth/bone fusion stimulator
☐	☐	Cochlear, otologic, or other ear implant
☐	☐	Insulin or other infusion pump
☐	☐	Implanted drug infusion device
☐	☐	Any type of prosthesis (eye, penile, etc.)
☐	☐	Heart valve prosthesis
☐	☐	Eyelid spring or wire
☐	☐	Artificial or prosthetic limb
☐	☐	Metallic stent, filter, or coil
☐	☐	Shunt (spinal or intraventricular)
☐	☐	Vascular access port and/or catheter
☐	☐	Radiation seeds or implants
☐	☐	Swan-Ganz or thermodilution catheter
☐	☐	Any metallic fragment or foreign body (e.g., bullets, shrapnel)

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YES	NO	
☐	☐	Tissue expander (e.g., breast)
☐	☐	Aortic stents/repairs
☐	☐	Hearing aid (Remove before entering MR system room)
☐	☐	Other implant: _____

I have read and understand the contents of this form. I attest that the above information is correct to the best of my knowledge.

Person Completing Form: _____
(Print Name and Sign)

Date:

For Office Use: Form Information Reviewed By:

_____
(Print Name and Sign)

Date: