

Centra Health
Lynchburg, Virginia
MRI Data/Consent For Diagnostic Testing

Warning: The following items can interfere with the MRI imaging and can be hazardous to your safety. Please check the appropriate boxes. Not all implants are MRI compatible. depending upon the implant, you may be asked to present an implant card before you are scanned. We apologize for any inconvenience, but this process is for YOUR safety. Thank you for your cooperation.

YES	NO	Cardiac pacemaker, Defibrillator or wires (can NEVER have MRI)_____
YES	NO	Head or Brain Surgery _____
YES	NO	Brain aneurysm clips _____
YES	NO	Eye Surgery _____
YES	NO	Ear surgery/inner ear implants _____
YES	NO	Heart Surgery _____
YES	NO	Aortic clips, heart valves _____
YES	NO	Carotid clips (neck arteries) _____
YES	NO	Vascular stents _____
YES	NO	Electrodes, neurostimulators, and TENS unit must be removed _____
YES	NO	Shunts or drainage tubes _____
YES	NO	Metal rods, pins, screws, or prosthesis, joint replacement _____
YES	NO	Spine surgery date _____ facility _____
YES	NO	Metal Mesh or wires sutures _____
YES	NO	Small Bowel Endoscopy Capsules (must be passed before scanning) _____
YES	NO	Shrapnel or gunshot wounds _____
YES	NO	Skin or Dermal patches like Nicoderm© must be removed _____
YES	NO	Latex allergy or sensitivity _____
YES	NO	Tattoos, tattoo eye liner, and glitter make-up may heat up during exam. <i>Please notify technologist if this should occur to simply stop the exam.</i> _____

YES	NO	Body piercings must be removed _____
YES	NO	Insullin pump, Infusion pump must be removed before entering the scan room _____
YES	NO	Hearing aids must be removed _____
YES	NO	Removable Dental Hardware (Dentures, Partials, or magnetic posts to hold Dentures) _____
YES	NO	Vena Cava filters, umbrella for blood clots _____
YES	NO	Do you currently have a wound dressing applied to skin? _____
YES	NO	Are you on daily Blood thinners like Aspirin, Coumadin or Plavix _____
YES	NO	Allergies to medications: _____

MALES:

YES	NO	Penile implants _____
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FEMALES:

YES	NO	Pregnant Last Menstrual Period: _____
YES	NO	Breast feeding. Please note if contrast is used, a minimal amount enters the breastmilk.
YES	NO	Breast Implants / tissue expanders _____

Patient/POA Signature: _____ **Date:** _____

Telephone Pre-Screening Signature: _____ **Date:** _____

Nurse/Technologist/Patient Coordinator Signature: _____ **Date:** _____