



WYOMINGIMAGINGCENTER

The Next Level of Imaging, The Next Level of Care

Warning: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. DO NOT ENTER the MR system room or MR environment if you have any question or concern about an implant, device, or object. Consult your MRI technologist or radiologist BEFORE entering the MR system room. **The MR system is ALWAYS ON.**

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Aneurysm clip(s)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Cardiac pacemaker
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Implanted cardioverter defibrillator
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Electronic implant or device
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Magnetically-activated implant or device
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Neurostimulation system
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Spinal cord stimulator
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Internal electrodes or wires
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Bone growth/bone fusion simulator
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Cochlear, otologic or other ear implant
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Insulin or other infusion pump
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Implanted drug infusion device
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Any type of prosthesis (eye, penile, etc.)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Eyelid spring or wire
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Artificial or prosthetic limb
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Metallic stent, filter or coil
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Shunt (spinal or intraventricular)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Vascular access port and/or catheter
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Swan-Ganz or thermodilution catheter
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Medication patch (nicotine, nitroglycerine)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Any metallic fragment or foreign
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tissue expander (e.g. breast)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Dentures of partial plates
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tattoo or permanent makeup
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Body piercing jewelry
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hearing aid
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other implant _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Breathing problem or motion disorder
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Claustrophobia

Note: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of form and have had the opportunity to ask questions regarding the information on this form.

Signature of person completing form: _____ Date: _____

Form completed by: ___ patient ___ relative ___ other If other, relationship to patient _____

Form information reviewed by: _____ Signature: _____