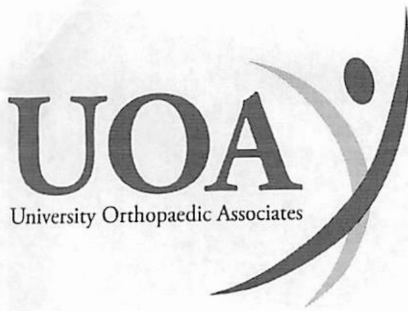

2 World's Fair Dr
Somerset, NJ 08873
732-537-0909

4810 Belmar Blvd.
Wall Twp., NJ 07753
732-938-6090

211 N Harrison St
Princeton, NJ 08540
609-683-7800

740 Rt. 1 N
Iselin, NJ 08830
732-853-8610

1000 Rt. 9 N, 306
Woodbridge, NJ 07095
732-283-2663

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MRI Safety Screening Form

Patient Name: ______________________________ Date: ____________________

Height: __________ Weight:

Please indicate if you have any of the following:

- ☐ Yes ☐ No Aneurysm clip(s)
- ☐ Yes ☐ No Cardiac pacemaker
- ☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
- ☐ Yes ☐ No Electronic implant or device
- ☐ Yes ☐ No Magnetically-activated implant or device
- ☐ Yes ☐ No Neurostimulation system
- ☐ Yes ☐ No Spinal cord stimulator
- ☐ Yes ☐ No Internal electrodes or wires
- ☐ Yes ☐ No Bone growth / bone fusion stimulator
- ☐ Yes ☐ No Cochlear, otologic, or other ear implant
- ☐ Yes ☐ No Insulin or other infusion pump
- ☐ Yes ☐ No Implanted drug infusion device
- ☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)
- ☐ Yes ☐ No Heart valve prosthesis
- ☐ Yes ☐ No Eyelid spring or wire
- ☐ Yes ☐ No Artificial or prosthetic limb
- ☐ Yes ☐ No Metallic stent, filter, or coil
- ☐ Yes ☐ No Shunt (spinal or intraventricular)
- ☐ Yes ☐ No Vascular access port and/or catheter
- ☐ Yes ☐ No Radiation seeds or implants
- ☐ Yes ☐ No Swan-Ganz or thermodilution catheter
- ☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
- ☐ Yes ☐ No Any metallic fragment or foreign body
- ☐ Yes ☐ No Wire mesh implant
- ☐ Yes ☐ No Tissue expander (e.g. breast)
- ☐ Yes ☐ No Surgical staples, clips, or metallic sutures
- ☐ Yes ☐ No Joint replacement (hip, knee, etc.)
- ☐ Yes ☐ No Bone / joint pin, screw, nail, wire, plate, etc.
- ☐ Yes ☐ No IUD, diaphragm, or pessary
- ☐ Yes ☐ No Dentures or partial plates
- ☐ Yes ☐ No Tattoo or permanent makeup
- ☐ Yes ☐ No Body piercing jewelry
- ☐ Yes ☐ No Hearing aid
- ☐ Yes ☐ No Other implant ____________________
- ☐ Yes ☐ No Breathing problem or motion disorder
- ☐ Yes ☐ No Claustrophobia

1) **Are you Pregnant?** Yes No N/A
2) **When did your symptoms Begin?** ______________________________
3) **Do you have any allergies?** Yes No
   If yes, please indicate: ______________________________
4) **History of cancer?** Yes No
   If yes, please indicate: ______________________________
5) **Any medical concerns at this time?** Yes No
   - **Diabetes** Yes No
   - **Kidney Disease** Yes No
   - **Smoker** Yes No

Other please specify: ______________________________

Signature of person completing this form: ______________________________

Reviewed By Level 1 or 2 Staff: (Print)____________________ Sign: ____________________

MRI Technologist: (Print) ____________________ Sign: ____________________