Valley Imaging Partners, Open MRI
690 Main St South, Suite 7LL, Southbury, CT

MRI SAFETY QUESTIONNAIRE

This questionnaire is designed to assist us in determining if it safe for you to undergo a magnetic resonance imaging procedure. It is important that you answer all the questions.

Height_____ Weight_____

Pervious surgeries or invasive procedure? **YES** or **NO**
If yes, please list ALL:

_____

_____

Do you have any of the following:

Cardiac pacemaker/defibrillator	**YES**	or	**NO**
Aneurysm clips	**YES**	or	**NO**
Intravascular stents, coils or filters	**YES**	or	**NO**
Electronic device: stimulator, medicine pump, loop recorder	**YES**	or	**NO**
Inner ear implant	**YES**	or	**NO**
Tattooed eye liner, lip liner, eyebrows	**YES**	or	**NO**
Penile implant	**YES**	or	**NO**
Shrapnel, BB's, or bullets	**YES**	or	**NO**
Hearing aids, removable dental work, braces	**YES**	or	**NO**
Trans dermal medicine patches	**YES**	or	**NO**
Fear of enclosed or narrow places	**YES**	or	**NO**
Possibility of being pregnant or breastfeeding	**YES**	or	**NO**

I certify that I have read and understand the questions above, and my responses are correct to the best of my knowledge. I understand it is my responsibility to disclose any metal fragments and/or implantation in my body, failing to do so may cause serious bodily injury or can be life threatening. I agree to release the center from any and all liability of injury.

_____ _____ DATE:_____
(signature patient or legal representative) (print name)

_____ _____ DATE:_____
(witness) (print name)

_____ _____ DATE:_____
(physician/technologist) (print name)