Clear Form

UW Health Partners
Watertown Regional Medical Center

Name: _____
DOB: _____ Age: ____
Weight in pounds: _____
(Wt. limit: 350 lbs)
Music preference: _____

MRI Screening & Eligibility Form

The following items may interfere with magnetic imaging and some MAY BE HAZARDOUS!!!
Please answer the following questions accurately to ensure safety & compatibility in the MRI scanner.
Do any of the following apply to you?

YES	NO	
○	○	Cardiac Pacemaker
○	○	Cardiac Defibrillator
○	○	Prosthetic Heart Valves
○	○	Heart Surgery or Cardiac Stents
○	○	Ventricular or Spinal Shunt
○	○	Prior Brain Surgery
○	○	Aneurysm Clips or IVC Filter
○	○	Prior L-spine surgery
○	○	Stomach or Colon Clips
○	○	Bio or Neuro Stimulator
○	○	InterStim or Electrode Implants
○	○	Any surgery in the last 6 weeks?
○	○	Do you do welding or grinding?
○	○	Hx of metal in your eyes?
○	○	Personal hx of Cancer

If yes, What kind ? _____

YES	NO	
○	○	Prior Eye Surgery
○	○	Middle Ear Prosthetics
○	○	Hearing Aids
○	○	Removable Dental Work
○	○	Metal Pins, Plates, Screws
○	○	Metal Fragments or Shrapnel
○	○	IUD or Pessary Ring
○	○	Pregnant or Breast Feeding
○	○	Insulin or Chemo Pump
○	○	Penile Implant
○	○	Medication or Smoking Patches
○	○	Piercings or Tattoos
○	○	Claustrophobic*

*Medication ordered by physician, MRI does not dispense meds

Information Source:
- ☐ Patient
- ☐ Family Member
- ☐ Nurse/MA
- ☐ Other

Complete for Contrast Exams*

YES	NO		Age
○	○	Age 60 or over	
○	○	Diabetes	
○	○	Kidney /Liver disease	
○	○	Hypertension	

*If answers "yes" to any then Creatinine and GFR will be required. (okay if within 30 days)

Creatinine: ____ GFR: ____

Date of lab: _____

Please accept the above electronic signature:

Screening Form Completed By: _____ Date: _____
(Patient / Caregiver Signature)
Enter Today's Date

Reviewed by: _____

PLEASE fax this form to 920-262-4555 when completed

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