B E C K E R
O R T H O P E D I C S
Advanced skills and experience for the results you deserve

MRI SCREENING SHEET

Patient Name:____

Date:_______________________ Date of Birth:________________

Please indicate if you have any of the following:

	Yes	No		Yes	No
Cardiac Pacemakers	☐	☐	Sheet Metal Worker	☐	☐
Brain/Abdomen Aneurysm clips	☐	☐	Carotid(neck) Clips	☐	☐
Aortic Clips	☐	☐	Ear Surgery	☐	☐
Implanted neurotransmitter	☐	☐	Heart valve replaced	☐	☐
Insulin pump	☐	☐	Heart Bypass	☐	☐
Hearing aids	☐	☐	Neurostimulators	☐	☐
Joint replacement	☐	☐	Electrodes	☐	☐
Fractured bones treated w/metal rods			Permanent Eyeliner	☐	☐
Plates, screws, nails or clips	☐	☐	Temp. Breast Implant	☐	☐
Prosthesis	☐	☐	IUD	☐	☐
Metal slivers in eyes	☐	☐	Shunt	☐	☐
Cochlear implants	☐	☐	Harrington Rod	☐	☐
Shrapnel	☐	☐	Wire Sutures	☐	☐
Pregnancy	☐	☐	Diabetic	☐	☐
Penile, Breast or Eye Prosthesis	☐	☐	Breastfeeding	☐	☐
Parkinson’s Implant Device	☐	☐	Metal Mesh	☐	☐
Have you ever had an MRI before	☐	☐	Seizure	☐	☐

If so, where and when?_______________________________
Other:____

NOTE:
Ensure that the following items are removed before scanning:

- Purse, wallet or money clip ☐
- Jewelry (for wrist and hand exams) ☐
- Watch, keys or pocket knife ☐
- Credit cards and bank cards with magnetic strip ☐

List all major surgeries:____________________________________
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Signature_________________________________ Date___________