NEUROSKELETAL IMAGING

Date of Birth:
Medical Record #:
Referring Physician: Accession #:

SAFETY CHECKLIST
CONTRAINDICATIONS

	YES	NO	IF YES, PLEASE EXPLAIN
Cardiac Pacemaker/Defibrillator	☐	☐	
Prosthetic Heart Valve	☐	☐	
Any Artificial Prosthetic	☐	☐	
Metal in Eyes/Exposure to Grinding Metal	☐	☐	
Surgical Clips in the Last 6 Weeks	☐	☐	
Programmable Brain Shunt	☐	☐	
Stapedectomy or Cochlear Implant	☐	☐	
Brain Aneurysm Surgery	☐	☐	
Implants, Stimulators or Pumps	☐	☐	
Permanent Eyeliner, Tattoos or Piercings	☐	☐	
Stents	☐	☐	
Penile Implant	☐	☐	
IUD (Intrauterine Device)/Pessary or Pregnant	☐	☐	
Ambulatory	☐	☐	
Transdermal Patch	☐	☐	
Tissue Expander (Breast)	☐	☐	
Hearing/Dentures	☐	☐	

WITH IV CONTRAST/GAD

Allergy to Latex	☐	☐
Breast Feeding	☐	☐
History of Kidney Disease/Dialysis	☐	☐
Sickle Cell Anemic	☐	☐
Diabetic	☐	☐
Respiratory Disease	☐	☐

ARTHROGRAM ONLY

Allergy to Contrast (CT, MRI or Xray), Iodine, Betadine or Shellfish	☐	☐
Blood Thinner Medications (including aspirin)	☐	☐
Allergy to Latex or Adhesive Tape	☐	☐

*****EVERYONE IN THE MAGNET ROOM DURING IMAGING MUST WEAR EAR PLUGS*****

Signature _____ **Date Signed:** _____

Witness: _____ **Date Signed:** _____