ZILKHA RADIOLOGY

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Patient Medical Clearance for MRI Scan

Date: ____________________________ **Chart #:** _____________

Patient Name: ____ **Date of Birth:** _____________

There are certain medical conditions/procedures that are not compatible with MRI testing. It is very important that you check the box if you currently have/or have had any of the procedures/conditions below:

Cardiac Pacemaker		Abdominal Surgery	
Metal Fragment in eye		Vascular Surgery	
Defibrillator		Prosthesis	
Intracranial Clips		Joint Replacement	
Aneurysm Clips		Metal Sutures	
Shrapnel		Wearing Dentures	
Hearing Aid		Wearing Bridges	
Neurostimulator		Wearing Retainer	
Insulin Pump		Wearing Palate Expander	
Pain Pump		New Tattoo/less than 6 wks	
Mechanical Heart Valve		Body Piercing	
Stent(s) or Filter		Wearing Drug/Pain Patch	
Back Surgery		History of Seizures	

If "**YES**" to above, please explain: ____

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I hereby state that the information listed above is accurate to the best of my knowledge.

Patient or Legal Guardian Signature ___________________________________ **Date**_____________