



Wisconsin River Orthopaedics, Ltd.

OPEN MRI PATIENT SAFETY FORM

Name: _____ Birth date: _____ Ht: _____ Wt: _____
(Please Print)

Yes	No	(Please hold any questions for the MRI Technologist)
<input type="checkbox"/>	<input type="checkbox"/>	Can you lie on your back for at least 45 minutes?
<input type="checkbox"/>	<input type="checkbox"/>	Are you claustrophobic or afraid of small places? Do you need medication? Yes or No
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been a machinist, welder, or metal-worker?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been hit in the face or eye with a piece of metal? (including metal shavings, slivers, bullets or BB's)
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant, possibly pregnant, or breast feeding?

DO YOU HAVE ANY OF THESE ITEMS IN OR ON YOUR BODY?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Brain / Aneurysm Clip	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac defibrillator(ICD), pacemaker, wires
<input type="checkbox"/>	<input type="checkbox"/>	Shunt(spinal or intraventricular)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery/Artificial Heart Valve/Angioplasty
<input type="checkbox"/>	<input type="checkbox"/>	Eye Implant/Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Coil/Filter/Stent in blood vessel (copy of implant card)
<input type="checkbox"/>	<input type="checkbox"/>	Ear Implant/Inner Ear Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Clips, Staples, Wires, Mesh or Sutures
<input type="checkbox"/>	<input type="checkbox"/>	Implanted Medication Pump	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Hardware (plates, screws, pins, rods)
<input type="checkbox"/>	<input type="checkbox"/>	Electrical Stimulator/Tens Unit	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Limb / Joint / Prosthesis
<input type="checkbox"/>	<input type="checkbox"/>	False Teeth or retainers	<input type="checkbox"/>	<input type="checkbox"/>	Colonoscopy, Bravo/Endo capsule, Pillcam (8weeks)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Iron injection past 3 months (ie:Feraheme,Ferumoxytol)
<input type="checkbox"/>	<input type="checkbox"/>	Body Piercing and/or Tattoos	<input type="checkbox"/>	<input type="checkbox"/>	Bullets/ BB's/Pellets/Shrapnel/Fragments
<input type="checkbox"/>	<input type="checkbox"/>	IUD, Penile Implant	<input type="checkbox"/>	<input type="checkbox"/>	Medication Patch(ie:Nicotine, Nitroglycerin, Estrogen,etc.)

I acknowledge that I understand that I have a choice of where I have my scan done, that there are other MRI clinic suppliers in the area. Below is a list of those within 25 miles:

Name	Phone	Miles	Address	Type of MRI
Aspirus Clinic	715/423-0122	0.1	2031 Peach Street	Permanent/installed
Marshfield Clinic	715/424/8600	0.1	220 North 24th St S	Portable - Truck
Riverview Hospital	715/423-6060	2	410 Dewey St	Permanent/installed
Aspirus Clinic	715/344-1600	19	5409 Vern Holmes Drive, Plover	Portable - Truck
St Michaels Hospital	715/346-5000	20	900 Illinois Ave, Stevens Point	Permanent/installed
Klasinski Clinic	715/344-0701	20	500 Vincent St, Stevens Point	Portable - Truck

The following items may become damaged or cause injury in a strong magnetic field and MUST NOT BE TAKEN INTO THE SCAN ROOM:

Watch/Jewelry Safety Pins Hair Pins/Barrette Keys/Coins Pocket Knife Wallet/Credit Cards

If you take medication to help you relax during the exam, you must have a driver to take you home.

Are you going to take medication to help you relax during the exam? Yes No
 (if Yes you must arrive 20 minutes early)

I acknowledge that I have read and completed the above safety form to the best of my knowledge.

 Signature of Patient, Parent or Guardian Date

Please bring this form with you to your examination.