University of Medical Center
Department of Radiology

Eligibility Checklist for Magnetic Resonance Imaging Protocols

MRI CANNOT BE PERFORMED UNLESS ALL ITEMS ARE ANSWERED

PATIENT IDENTIFICATION

PATIENT'S NAME

MED. REC. NO.	WEIGHT	AGE

PATIENT CRITERIA

A. ARE YOU PREGNANT? (DATE OF LMP: _____) B. EMERGENCY ☐ YES ☐ NO

PLEASE ✓ CHECK	YES	NO		YES	NO
ANEURYSM CLIPS			RENAL TRANSPLANT CLIPS		
INTRACRANIAL CLIPS			CORONARY ARTERY CLIPS		
FOREIGN OBJECTS IN EYE			**CARDIAC PACEMAKER / AICD / WIRES**		
METAL WORKER / WELDER / GRINDING			CARDIAC VALVE PROSTHESIS		
TATTOO / PERMANENT EYE LINER			**IMPLANTED CARDIAC DEFIBRILLATOR**		
SHRAPNEL, METALLIC SPLINTERS OR OTHER FOREIGN BODIES			ARTIF. LIMB / JOINT PROSTHESIS		
ORBITAL PROSTHESIS			**NEURO / BIO-STIMULATOR**		
MIDDLE EAR PROSTHESIS			VENA CAVA FILTER		
PRIOR SURGERY			**IMPLANTED PUMP**		
OTHER VASCULAR CLIPS			ASTHMA		

(PATIENT UNABLE TO COMPLETE)

M.D.

FILMS CLEARED *(RADIOLOGIST ONLY)*

☐ SKULL ☐ CHEST X-RAY ☐ OTHER

M.D.

I HAVE REVIEWED/EDUCATED THE PATIENT AND/OR REQUESTING PHYSICIAN CONCERNING THE ABOVE CRITERIA

NAME MD/RN/RT

PHYSICIAN NUMBER

SIGNATURE MD/RN/RT

DATE

I UNDERSTOOD AND CORRECTLY ANSWERED ALL OF THE ABOVE STATEMENTS

SIGNATURE OF PATIENT OR PERSON TO COMPLETE FOR PATIENT

DATE

PRINT NAME

RELATIONSHIP TO PATIENT

WHITE COPY - MEDICAL RECORDS YELLOW - CHART COPY

(4/01)