IMPLANTABLE FORM

Patient Name: _____ Date of Visit: _____/_____/_____

MR#_____ Doctor: _____, M.D.

Please indicate if you have any of the following:

☐ Yes	☐ No	Cardiac pacemaker or making wires
☐ Yes	☐ No	Implanted cardioverter defibrillator (ICD)
☐ Yes	☐ No	Cochlear, otologic, or other ear implant
☐ Yes	☐ No	Tissue Expander (e.g., breast)
☐ Yes	☐ No	Implanted drug infusion device
☐ Yes	☐ No	Aneurysm clip(s), When_____
☐ Yes	☐ No	Neuro-stimulator (Deep Brain Stimulator)
☐ Yes	☐ No	Other Stimulator: _____
☐ Yes	☐ No	Prosthesis (eye, penile, limb, etc...)
☐ Yes	☐ No	Artificial heart valve
☐ Yes	☐ No	Eyelid spring or wire
☐ Yes	☐ No	Stent, filter, or coil
☐ Yes	☐ No	Programmable shunt
☐ Yes	☐ No	Catheter or feeding tube with metal tip
☐ Yes	☐ No	Radiation seeds
☐ Yes	☐ No	Medication patch (Nicotine, Nitroglycerine)
☐ Yes	☐ No	Any metallic fragment, foreign body or bullets
☐ Yes	☐ No	Surgical staples, clips, metallic sutures, or wire mesh
☐ Yes	☐ No	Bone/joint pin, screw, nail, wire, plate, etc…
☐ Yes	☐ No	IUD, diaphragm, or pessary
☐ Yes	☐ No	Dentures or braces
☐ Yes	☐ No	Hearing aid (Remove before entering the MR system room)
☐ Yes	☐ No	Tattoo, permanent makeup or body piercing jewelry
☐ Yes	☐ No	Breathing problem or motion disorder
☐ Yes	☐ No	Claustrophobia
☐ Yes	☐ No	Hair extensions