Name of Policy: **MRI Contraindications** **Policy Number**: 3364-135-064 **Approving Officer**: Chief Executive Officer **Responsible Agent**: Assistant Professor & Deputy Clinical Service Chief Director Radiology **Scope**: The University of Toledo Medical Center Radiology	UTOLEDO HEALTH **Effective date:** **Original effective date**: July 14, 1999
Key words: Contraindications, patient safety, liability, MRI screening form, Patient Safety	

	New policy proposal	X	Minor/technical revision of existing policy
	Major revision of existing policy		Reaffirmation of existing policy

(A) Policy statement

Patients undergoing MRI scanning must be screened for contraindications prior to being scanned.

(B) Purpose of policy

To ensure patient safety and reduce the liability of The University of Toledo Medical Center (UTMC).

(C) Procedure

At the time of ordering, physicians are requested to answer key questions about their patient which help screen for contraindications.

(1) Upon the patient's arrival, the MRI technologists must review the list of MRI contraindications on the MRI screening form with the patient.

(2) Any implant or foreign bodies must be cleared by MR ~~safe~~conditional card, operative notes compared to MRI Safety Manual (Shellock & Kanal), -manufacturer specifications and/or negative x-ray done at UTMC and checked out by UTMC radiologist/MRI safety medical director.

(3) Documentation of clearance must exist prior to patient entering Zone 4.

(4) If a contraindication exists:

(a) Referring physician is contacted to advise of contraindication.
(b) The study is cancelled unless the referring physician feels the benefits of scanning outweigh the risks by a significant margin, agrees to take total responsibility, and obtains consent from the patient.
(c) Documentation is entered into ~~RIS~~EPIC for future reference.
(d) The consent form will be forwarded to the HIM department for scanning into the patient's permanent medical record.

Approved by:

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Date

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Date

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Date

Review/Revision Completed by:
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Policies Superseded by this Policy:

- M-005

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Next review date:

MRI SCREENING FORM

The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. Therefore, **all** individuals are required to fill out this form BEFORE entering the MR environment or MR system room.
Be advised, the MR system magnet is ALWAYS on!
IMPORTANT INSTRUCTIONS!
Remove **all** metallic objects before entering the MR environment or MR system room including hearing aids, beeper, cell phone, keys, eyeglasses, hair pins, barrettes, jewelry (including body piercing jewelry), watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, ~~pocket knife~~pocketknife, nail clipper, steel-toed boots/shoes, and tools. Loose metallic objects are especially ***prohibited*** in the MR system room and MR environment.

PATIENT INFORMATION/HISTORY
HEIGHT: _____ WEIGHT: _____
REASON FOR MRI: _____
SYMPTOMS/REASONS FOR MRI _____
_____
If female, date of last menstrual period_____
IUD ☐YES ☐NO

☐ YES ☐ NO Claustrophobic
☐ YES ☐ NO Sedation Required
☐ YES ☐ NO Patient on Vent
☐ YES ☐ NO High Blood Pressure
☐ YES ☐ NO Diabetic
☐ YES ☐ NO History of Renal Disease
☐ YES ☐ NO Solitary Kidney
☐ YES ☐ NO Renal Cancer
☐ YES ☐ NO Renal Surgery
☐ YES ☐ NO Kidney Transplant
☐ YES ☐ NO Prior Dialysis
☐ YES ☐ NO Current Dialysis
☐ YES ☐ NO Allergies ___ _____
☐ YES ☐ NO Have you had blood tests within the last 30 days? If yes, what type _____
_____

UTOLEDO HEALTH

#1 Do you/the patient have ***ANY*** of the following:
If **YES**, you /the patient ***CANNOT*** have an MRI. ***Notify physician that MRI cannot be done.***
If NO, please continue to Step 2.

☐ YES ☐ NO Cardiac Pacemaker
☐ YES ☐ NO Implanted Defibrillator
☐ YES ☐ NO Internal Pacing Wires
☐ YES ☐ NO Brain Aneurysm Clips
☐ YES ☐ NO Breast Expanders
☐ YES ☐ NO Other _____

#2 Do you/the patient have ANY of the following:
If **YES**, provide information about the device; include ID cards, implantation date(s). This is ***VITAL*** to the safety of the patient. Consult MRI technologist or Radiologist for safety of device. If **NO**, continue to Step 3.

☐ YES ☐ NO Aneurysm Clips (other than Brain)
☐ YES ☐ NO Cochlear Implant
☐ YES ☐ NO Stents-Heart If yes, when_____ & where _____
☐ YES ☐ NO Stents-Other If yes, when _____ & where _____
☐ YES ☐ NO Neurostimulator
☐ YES ☐ NO Bone Growth Stimulator
☐ YES ☐ NO Shunt (Spinal or Brain)
☐ YES ☐ NO Implanted Drug Delivery System
☐ YES ☐ NO Vascular Access Port
☐ YES ☐ NO IVC Filter or Greenfield Filter If yes, when _____ & where_____
☐ YES ☐ NO Shrapnel, Bullets, or BBs
☐ YES ☐ NO History of metal grinding
☐ YES ☐ NO Metal Slivers, shavings, etc. in eyes ***(ever)***
☐ YES ☐ NO Any type of prosthesis (limb, eye, penile)
☐ YES ☐ NO Other _____

Date completed _____ ☐ YES ☐ NO Have you had any surgeries? If YES, what type? _____ ☐ YES ☐ NO Previous MRI If yes, what type _____ Date Completed _____ ☐ YES ☐ NO Have you had any X-rays, CT Scan, Bone Scan, or Ultrasound exams done? If yes, what type: _____ Date Completed: _____ ☐YES ☐ NO Have you ever been given an injection of contrast? ☐ YES ☐ NO If yes, did you experience a reaction and please describe the reaction _____	***#3*** Do you/the patient have **ANY** of the following: If **YES, *REMOVE ITEMS,*** if possible. Be sure to consult the MRI Technologist or Radiologist for Safety Instructions if there are any questions or concerns. Thank you! ☐ YES ☐ NO Hearing Aids ☐ YES ☐ NO Insulin or Infusion Pump ☐ YES ☐ NO Transdermal Delivery System/Medication Patch ☐ YES ☐ NO Tattoo/Tattooed Make Up ☐ YES ☐ NO Body Piercing ☐ YES ☐ NO Harrington Rods ☐ YES ☐ NO Orthopedic Hardware, Joint Prosthesis ☐ YES ☐ NO Dentures ☐ YES ☐ NO Breast Implants ☐ YES ☐ NO Other _____