Name of Policy:	**MRI Contraindications**
Policy Number:	3364-135-064
Department:	Radiology
Approving Officer:	Chief Operating Officer - UTMC
Responsible Agent:	Chairman & Professor, Radiology
Scope:	Radiology

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Effective Date: 5/1/2023

Initial Effective Date: 7/14/1999

_____ New policy proposal	_____ Minor/technical revision of existing policy
_____ Major revision of existing policy	**X** 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.

(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 card, operative notes compared to MRI Safety Manual (Shellock & Kanal), and/or negative x-ray done at University of Toledo Medical Center 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 outweighs the risks by a significant margin, agrees to take total responsibility, and obtains consent from the patient.
   c.) Documentation is entered into RIS 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:

/s/ — 04/04/2023
Haitham Elsamaloty, MD — Date
Chairman & Professor, Radiology

/s/ — 04/11/2023
Christine Stesney-Ridenour, FACHE — Date
Chief Operating Officer - UTMC

Review/Revision Completed By:
Haitham Elsamaloty, MD

Review/Revision Date:
9/1/2005
5/23/2008
5/1/2011
5/22/2014
5/1/2017
5/1/2020
5/1/2023

Next Review Date: 5/1/2026

Policies Superseded by This Policy: M-005

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, nail clipper, steel-toed boots/shoes, and tools. Loose metallic objects are especially ***prohibited*** in the MR system room and MR environment.

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#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 _____

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 _____
_____
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 _____

#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 _____

#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 _____

Signature of Patient or Person Completing Form: _____ Date: _____
☐ Patient ☐ Relative Relationship: _____

Form Reviewed by: ☐ Technologist Signature _____
☐ Radiologist Signature _____