DATE: _______________

Patient Name:
Sex: M F
Date of birth:
Address:
City:
Parent / guardian:
Telephone: #

Request for verification of MRI-Safe Implants

This Form is intended to be filled out by the implanting surgeon as an indication that it is safe for the patient named on this form to be scanned in a 3T MRI scanner.

1. Will the patient feel any discomfort at the site of implant?
❑ Yes ❑ No

Patient weight _______ kg Height _______ cm Age: ______________

2. Briefly explain the device that has been implanted in this patient. (anatomical site, symptoms, clinical findings)

Has this person been scanned before ❑ **Prior to Implant** ❑ **After Implant**
(please specify the details of each scan)

4. Additional relevant history and comments (previous reaction to contrast, allergies, isolation, cardiac anomaly, special positioning, etc.)

5. Preferred date of exam:

____

Reasons for the preferred date:

6. Surgeon's Information

First name: ________________________ Last name: _________________________ Department: ________________________________

Address: ____ Fax #: _____________________________

Contact numbers: 1. ____ 2. ____

7. Surgeon's Signature: ______________________________ Print name: ____________________________________

NYSPI STAFF Requesting the Proof name: _____________________________ Date: ______________ Time: _________

I have reviewed the above information and approve the participant for scanning - PI Signature ______________________________

Incomplete, illegible or inaccurate forms will be returned to you, resulting in a delay in obtaining an appointment.