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

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