



# The Mount Sinai Hospital

One Gustave L. Levy Place  
New York, New York 10029

Name: JEFFREY EPSTEIN

DOB: 01/20/1953 Gender  M  F

## DEPARTMENT OF RADIOLOGY MAGNETIC RESONANCE IMAGING (MRI) PATIENT SCREENING QUESTIONNAIRE

MRN: \_\_\_\_\_

Location: \_\_\_\_\_

Physician: \_\_\_\_\_

**INSTRUCTIONS:** Please answer each question below. Your responses will allow us to determine your eligibility for an MRI scan. Each box should be marked **individually**—please do not simply draw a line down a column.

Yes No

- 1. Do you have a **pacemaker, AICD, internal pacing wires, EKG leads or Holter monitor?**
- 2. Have you had **brain surgery** or do you have **metallic clips (aneurysm clips)** in your head?
- 3. Do you have an implanted **stimulator (including bone growth stimulator, spinal stimulator or cochlear or other ear implant)** or **medication infusion pump?**
- 4. Have you ever had **eye surgery or implants?**
- 5. Have you ever worked around a **metal lathe, had metal shavings or fragments** in your eye(s), or had a **shrapnel (war or gunshot) injury** anywhere in your body?
- 6. Have any devices (e.g., **stent, filter, coil or vascular port/catheter**) been placed in your blood vessels?  
5a. If you do have a stent, is it **drug-eluting?**
- 7. Do you have an implanted **tissue expander?**
- 8. Do you have a **replaced heart valve, other prosthesis** or any other **surgical implant?**
- 9. Do you have any **tattoos, permanent make-up, or piercings?**
- 10. Do you wear **hearing aid(s)**, either in the ear canal or on the surface? (*Remove before entering room*)
- 11. Do you wear a **transdermal medication patch** (e.g., Nitroglycerin, Nicotine, etc.)?
- 12. Do you have **kidney/renal disease, liver disease, or diabetes?**
- 13. Do you have any **allergies?** If so, specify: \_\_\_\_\_
- 14. Are you **claustrophobic** (afraid of enclosed or tight spaces)?
- 15. Are you wearing a **RFID or Radiofrequency ID device** (commonly a wristband on an inpatient)?
- 16. If female, are you (or could you be) **pregnant** or are you **breastfeeding?**
- 17. List any **other** type of metal in or on your body: \_\_\_\_\_
- 18. Patient age: 63 years
- 19. Approximate patient **weight:** 170 (pounds) and patient **height:** \_\_\_\_\_ (feet-inches)



**WARNING:** Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device or object. Consult the MRI Technologist or Radiologist BEFORE entering a MR system room. **The MR magnet is ALWAYS on.**

20. Please print name, sign, date and time

JEFFREY EPSTEIN  
PRINTED NAME

Patient  Physician  
 Relative  Other:

[Signature]  
SIGNATURE

12/15/2014 : \_\_\_\_\_  
DATE TIME

FOR COMPLETION BY MRI PERSONNEL REVIEWING FORM


RFID removed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE <u>  /  /  </u>
MRI TECHNOLOGIST _____	TECH SIGNATURE _____
DATE <u>  /  /  </u>	TIME <u>  :  </u>
MRI NURSE _____	NURSE SIGNATURE _____
DATE _____	TIME <u>  :  </u>