RADIOLOGY SERVICES OF NEW YORK, P.C.
2777 Hylan Blvd. Staten Island, NY 10306
Tel. (718) 979-0100 Fax (718) 979-3602
www.rsny.net

MRI SCREENING FORM

Name: _____

Cardiac Pacemaker	YES_____NO_____
Intracranial Aneurysm Clips	YES_____NO_____
Metal in Eyes	YES_____NO_____
Electronic Implants	YES_____NO_____

If yes, please list _____

Are you pregnant?	YES_____NO_____
Did you have a stent placed in the last 6 weeks?	YES_____NO_____
Any other devices/metal implanted in your body	YES_____NO_____

If yes, please list _____

_____ Date

_____ Signature

Referring Physicians can view images or reports by visiting our website at www.rsny.net and following Physician's login link. Please call us for your user name and password.