MRI Procedure — Safety Questionnaire

SURNAME: _____

FORENAME: _____

DATE OF BIRTH: _____/_____/_____ Address----------
Phone_____ WEIGHT: _____(kgs)

WARNING: Due to the presence of the strong magnetic field certain implants, devices or objects may be hazardous to you and/or may interfere with the MR procedure. **DO NOT ENTER** the Magnet Room or the MR environment if you have any questions or concern regarding an implant, device or object. Consult a member of **MRI staff** before entering the Magnet Room. The MR system magnet is **ALWAYS** on.

Please answer & tick Yes/No to the following questions:		**YES**	**NO**
1.	Have you had an MRI procedure before?		
2.	Do you have, or ever have had, a cardiac pacemaker, pacing wires, an artificial heart valve, cochlea implant, hearing aids, programmable hydrocephalus shunt or neuro stimulator?		
3.	Have you ever had any heart or head surgery?		
4.	Have you ever had any surgery involving the use of metal implants, plates or clips?		
5.	Have you had any surgery within the last two months?		
6.	Have you EVER had metal fragments in your eyes?		
7.	Have you EVER had any metal fragments in any other part of your body? E.g. bullets, shrapnel, weld?		
8.	Do you wear dentures, a dental plates with/without metal or a brace? (NOT FILLINGS)		
9.	Do you have any of the following? (Please circle)		
	Tattoos / Piercings / Body Jewellery / Limb or Prothesis / Medicine Patches (e.g. HRT, Nicotine replacement, Pain relief)		

FOR FEMALE PATIENTS ONLY:

1.	Is there any possibility that you could be pregnant?		
2.	Are you breast-feeding?		
3.	Do you have an IUD coil fitted?		

PATIENT DECLARATION: By signing below you acknowledge that:

1. You confirm that the information provided is accurate to the best of your knowledge.
2. You have had an opportunity to ask questions regarding the information on this form and regarding the MR procedure that you are about to undergo.
3. **BEFORE** entering the Magnet Room, you will remove **ALL** metal objects including coins, jewellery, hair pins, body piercing, false teeth, hearing aids, pens, tools, analogue watches and credit cards.
4. Please be advised, as part of this exam you will be required to wear hearing protection.

Patient Signature: _____ **Date: _____/_____/_____**

Radiographer Signature: _____

Comments:

_____

IF YOU REQUIRE MRI CONTRAST INJECTION FOR YOUR PROCEDURE PLEASE TURN THIS PAGE

MRI Procedure — Intravenous Cannulation

affidea
- Nothing is more important than health

The following is for patients that require IV Cannulation		**YES**	**NO**
1.	Are you currently on any blood-thinning medication? E.g. warfarin, aspirin		
2.	Are you allergic to any MRI Contrast?		
3.	Do you have diabetes (If so, what type?)		
4.	Do you have asthma?		
5.	Do you suffer from renal disease?		
6.	Have you ever had or awaiting a renal or a liver transplant?		
7.	Do you have any allergies? If so, please list below:		

For patients requiring the injection of Buscopan

Do you suffer from any of the following:

1.	Myasthenia Gravis - Weakness in Voluntary muscles particularly Eyes and Face		
2.	Megacolon – Abnormal dilation of Colon		
3.	Narrow angle glaucoma – fluid build-up behind Iris, increased intraocular pressure		
4.	Prostatic enlargement – Enlarged gland with bladder retention of urine		
5.	Tacchycardia – abnormally high (Over 100 bpm) resting heart beat		
6.	Paralytic ileus – Obstruction of intestine due to paralysis of intestine muscles		
Do you give your consent should an injection of Buscopan be required?			

Patient Signature: _____ **Date:** _____/_____/_____

FOR OFFICAL OFFICE USE ONLY:

CONTRAST	Batch No.	Expiry	Dose	Injected by:

BUSCOPAN	Batch No.	Expiry	Dose	Injected By:

Creatinine	eGFR	Creatinine

Radiographer's signature: _____