

Magnetic Resonance Imaging (MRI) – Patient Safety Questionnaire



Full Name:		Preferred Name:	
First line of address:			
Pt ID:		Date of Birth:	
Weight:		Height:	

Please complete this form and bring it with you to your scan appointment. Due to the nature of the magnetic field the questions will help to identify anything that might interfere with your scan or prevent it from proceeding on safety grounds. Answer the questions carefully, providing any additional details as requested.

If you answer 'yes' to any of Q's2 -5 (and Q7 where applicable) or have any questions of your own, please refer to your appointment letter on the best way to contact us before your scan appointment.

1. Have you had an MRI Scan before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you have, or have you ever had, a cardiac pacemaker or internal defibrillator?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever had any surgery or procedures to your: a) Head/Brain – such as cerebral aneurysm clips or a hydrocephalus shunt? b) Eyes – such as a retinal tack? c) Ears – such as Cochlear implant or stapedectomy? d) Heart – such as artificial heart valve or loop recorder? e) Blood Vessels – involving stents, clips, coils or filters? f) Any other part of your body?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
4. Do you have, or have you ever had, any medical devices attached to your body? e.g. drug port, infusion pump or neurostimulator.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you ever had a penetrating injury to your eyes involving metal? Please tick YES even if the metal was removed at a hospital or occurred some years ago.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
List ALL previous surgeries or interventions:		
6. Any retained metallic fragments from a previous injury, such as shrapnel?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Are you, or could you be, pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Do you suffer from: (tick as applicable) <input type="checkbox"/> blackouts <input type="checkbox"/> epilepsy <input type="checkbox"/> diabetes <input type="checkbox"/> asthma		
9. Do you have any of the following: (tick as applicable) <input type="checkbox"/> hearing aid <input type="checkbox"/> dentures <input type="checkbox"/> artificial limb/calipers <input type="checkbox"/> surgical corset <input type="checkbox"/> skin patch <input type="checkbox"/> permanent cosmetics/tattoos <input type="checkbox"/> false eye <input type="checkbox"/> body piercings <input type="checkbox"/> glucose monitor <input type="checkbox"/> wearable devices		

Before your scan you must remove all electrical or metallic objects you are wearing or have in your pockets – e.g. Jewellery • Watches • Keys • Credit Cards • Body Piercings • Hair Clips • Coins.

Please remove as much as possible before arrival for your appointment, preferably wearing light weight clothing with minimal metal fastenings. Please note: you may be asked to change into a gown or scrubs to have your MR scan.

Patient Declaration: I confirm that I have read and completed the above questions, and that the information provided is correct to the best of my knowledge. I have had the examination adequately explained and understand the need for ear protection and ensuring it is fitted correctly. I consent to proceed with the MRI examination.

Signed: _____ Date: _____

Validating Radiographer: Name (print): _____ Signed: _____ Date: _____ Hearing Protection Explained & Given: <input type="checkbox"/> Earplugs <input type="checkbox"/> Ear defenders/Headphones <input type="checkbox"/> Both	Scanning Radiographer: Name (print): _____ Signed: _____ Date: _____ No of Series: _____ No of Images: _____ <input type="checkbox"/> Images sent to PACS <input type="checkbox"/> Images confirmed on PACS
---	---