PATIENT STICKER	IV CANNULATION STICKER

bmi
barwon medical imaging
APPOINTMENTS / ENQUIRIES
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PATIENT SAFETY QUESTIONNAIRE FOR MRI

Please read and tick "Yes or No". Do not hesitate to ask questions if you are unsure about anything.
Please bring the completed form with you to your MRI appointment.

Patient Details

Name_____UR No_____

Date of Birth_____/_____/_____Weight_____Height_____

Do you/have you had:

*Please tick yes or no in each section

Cardiac Pacemaker/Retained Intracardiac Leads/ Defibrillator?	Yes ☐ No ☐
Cerebral Aneurysm Clip/ Cerebral Vascular Clip/Coil?	Yes ☐ No ☐
Electronic devices implanted eg. Spinal Stimulator?	Yes ☐ No ☐
Cochlear/Stapes Implant in ear?	Yes ☐ No ☐
Endoscopy Capsule?	Yes ☐ No ☐
Metal injury to eyes?	Yes ☐ No ☐
Stent(s), Coils or Filters in your heart or blood vessels?	Yes ☐ No ☐
Is there any possibility you may be pregnant?	Yes ☐ No ☐

If you answered "yes" to any of the above questions you may not be safe to have an MRI scan. Please ring us to discuss these questions

Technologist / Nurse (Office Use Only)

1._____ 2._____

Have you had:

*Please tick yes or no in each section

Surgery on your head?	Yes ☐ No ☐
Surgery on your heart/chest?	Yes ☐ No ☐
Surgery on your back?	Yes ☐ No ☐

Are you claustrophobic (find enclosed spaces uncomfortable)? Yes ☐ No ☐
If yes please ring prior to appointment.

Have you had an MRI scan before? Yes ☐ No ☐

If so when & where?_____

_____

Do you have any of the following:

*Please tick yes or no in each section

Brain Shunt Tube with magnetically activated valve?	Yes ☐ No ☐
Bullets or shrapnel in your body?	Yes ☐ No ☐
Any type of prosthesis?	Yes ☐ No ☐
Heart valve replacement?	Yes ☐ No ☐
Colonoscopy Clip?	Yes ☐ No ☐
Pins / plates/ screws/ rods in bones?	Yes ☐ No ☐
Tattoos?	Yes ☐ No ☐
Body piercing jewellery?	Yes ☐ No ☐
Magnets on your body?	Yes ☐ No ☐
Hearing aids?	Yes ☐ No ☐
Dentures / false teeth / partial plate?	Yes ☐ No ☐
Nicotine or any other patches?	Yes ☐ No ☐

Do you/have you had:

*Please tick yes or no in each section

Asthma?	Yes ☐ No ☐
Kidney disease?	Yes ☐ No ☐
Hypertension?	Yes ☐ No ☐
Blood disorder?	Yes ☐ No ☐
Diabetes?	Yes ☐ No ☐
Have you had an allergic reaction to medication or contrast media (x-ray dye)?	Yes ☐ No ☐
Are you breastfeeding?	Yes ☐ No ☐

Office use only

Consent _____

Witnessed _____