

MRI Patient Safety Questionnaire

{Affix Patient Label Here}	Patient Name	<input style="width: 100%;" type="text"/>		
	Date of Birth	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>
	Weight	<input style="width: 100%;" type="text"/>		Height
	<input style="width: 100%;" type="text"/>			<input style="width: 30px;" type="text"/>

Please bring this form and your request form/letter to your appointment. For any surgical implants please provide make and model number of the implant below.	Yes	No
Have you ever had an MRI scan before?	<input type="checkbox"/>	<input type="checkbox"/>

Please answer the below questions carefully, some medical implants/ conditions can interfere with your health during the MRI. If you answer YES to any of the following, please contact cityradiographer@fortiusclinic.com as you MAY NOT be able to have an MRI.	Yes	No
Do you have a pacemaker? We cannot scan any pacemakers including MRI conditional	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery to your heart? <i>If so please list eg. Stents / heart valve replacement / PFO closure etc</i>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery to the head/brain? <i>If so please list</i>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery to your eyes/ears? <i>If so please list</i>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a Cochlear implant? <i>Implanted hearing aid</i>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear hearing aids? <i>These need to be removed for the scan</i>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any electronic/mechanical/magnetic implants? <i>Eg. Neurostimulators / cardiac loop recorders / insulin pumps etc</i>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any metal fragments/slivers in your eye from an injury? <i>Eg. Accidents / welding / grinding etc</i>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever undergone a capsule endoscopy where you ingested a small capsule/camera? <i>You will not be able to have your MRI if the capsule may still be inside your body.</i>	<input type="checkbox"/>	<input type="checkbox"/>
Could you be pregnant? We cannot scan during the 1st trimester <i>If yes when was your L.M.P?</i>	<input type="checkbox"/>	<input type="checkbox"/>

If you answer YES to any of the following we need to know the details but you will usually be able to proceed with your scan <i>For any surgical implants please provide make and model number of the implant.</i>	Yes	No
Have you ever had surgery involving metal implants/clips/plates? <i>Eg. Joint replacement / stent / mesh etc</i>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have anything else implanted under the skin?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any surgery to your spine? <i>If so please list</i>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear a caliper or have an artificial limb?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any metal fragments in any other part of the body? <i>Eg. Bullets / shrapnel etc</i>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently wearing any drug skin patches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any permanent eye make-up/tattoos/body piercings?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies? <i>If so please list</i>	<input type="checkbox"/>	<input type="checkbox"/>

I confirm that I have been asked the above questions and the information is correct to the best of my knowledge.

Signature of Patient	<input style="width: 95%;" type="text"/>	Date	<input style="width: 95%;" type="text"/>
Signature of Radiographer	<input style="width: 95%;" type="text"/>	Date	<input style="width: 95%;" type="text"/>