fortiusclinic

# MRI Patient Safety Questionnaire

| {Affix Patient Label Here} | **Patient Name** | | | | | |
|---|---|---|---|---|---|---|
| | **Date of Birth** | | **Weight** | | **Height** | |

| Please bring this form and your request form/letter to your appointment.<br>***For any surgical implants please provide make and model number of the implant below.*** | Yes | No |
|---|---|---|
| **Have you ever had an MRI scan before?** | ☐ | ☐ |

| 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 | ☐ | ☐ |
| **Have you ever had surgery to your heart?**<br>***If so please list eg. Stents / heart valve replacement / PFO closure etc*** | ☐ | ☐ |
| **Have you ever had surgery to the head/brain?**<br>***If so please list*** | ☐ | ☐ |
| **Have you ever had surgery to your eyes/ears?**<br>***If so please list*** | ☐ | ☐ |
| **Do you have a Cochlear implant?** ***Implanted hearing aid*** | ☐ | ☐ |
| **Do you wear hearing aids?** These need to be removed for the scan | ☐ | ☐ |
| **Have you ever had any electronic/mechanical/magnetic implants?**<br>***Eg. Neurostimulators / cardiac loop recorders / insulin pumps etc*** | ☐ | ☐ |
| **Have you ever had any metal fragments/slivers in your eye from an injury?**<br>***Eg. Accidents / welding / grinding etc*** | ☐ | ☐ |
| **Have you ever undergone a capsule endoscopy where you ingested a small capsule/camera?** ***You will not be able to have your MRI if the capsule may still be inside your body.*** | ☐ | ☐ |
| **Could you be pregnant?** **We cannot scan during the 1st trimester**<br>***If yes when was your L.M.P?*** | ☐ | ☐ |

| 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<br>***For any surgical implants please provide make and model number of the implant.*** | Yes | No |
|---|---|---|
| **Have you ever had surgery involving metal implants/clips/plates?**<br>***Eg. Joint replacement / stent / mesh etc*** | ☐ | ☐ |
| **Do you have anything else implanted under the skin?** | ☐ | ☐ |
| **Have you ever had any surgery to your spine?**<br>***If so please list*** | ☐ | ☐ |
| Do you wear a caliper or have an artificial limb? | ☐ | ☐ |
| **Have you ever had any metal fragments in any other part of the body?**<br>***Eg. Bullets / shrapnel etc*** | ☐ | ☐ |
| **Are you currently wearing any drug skin patches?** | ☐ | ☐ |
| **Do you have any permanent eye make-up/tattoos/body piercings?** | ☐ | ☐ |
| **Do you have any allergies?**<br>***If so please list*** | ☐ | ☐ |

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

| **Signature of Patient** | | **Date** | |
|---|---|---|---|
| **Signature of Radiographer** | | **Date** | |

If you have any queries please e-mail: cityradiographer@fortiusclinic.com