MRI SAFETY QUESTIONNAIRE

Name: **Age:**
Date of Birth: **Weight:** kg **Height:** cm

The following questions are to ensure you are safe to proceed with your MRI scan. Please answer these truthfully and to the best of your knowledge. Certain implants and devices may be hazardous in the MRI scanner or may interfere with your MRI scan.

Have you:

Had a previous MRI examination before?	☐Yes	☐No
If yes, when and where? ______________________________		
Had an operation of any kind?	☐Yes	☐No
If yes, what operation(s) and approximate dates ______________________________		
______________________________		

Do you have any of the following?

Heart/Cardiac:	☐Yes	☐No	**Brain and Spine:**	☐Yes	☐No
Pacemaker			Aneurysm clip		
Defibrillator			Shunt		
Pacing wires			Neuro or spinal stimulator		
Heart valve					
Vascular:	☐Yes	☐No	**Implant:**	☐Yes	☐No
Implant			Eye		
Stent			Ear		
Coil			Penile		
Filter			Drug infusion pump		
Aortic graft			Other		

If you answer yes to any of these questions, please call (02) 4990 2655 prior to your booking

Joint replacement, artificial limb, metal rods, pins, plates or screws in/on bones	☐Yes	☐No
Metal/shrapnel/bullet injuries	☐Yes	☐No
False teeth/removable bridgework or hearing aid	☐Yes	☐No
Body piercing, tattoos or nicotine or medication patches	☐Yes	☐No
Have you ever had metal in your eyes or worked extensively with metal?	☐Yes	☐No
If yes, has it been removed?	☐ Yes	☐ No
Do you have a history of kidney (renal) disease?	☐Yes	☐No
Have you ever had an allergic reaction to contrast media?	☐Yes	☐No
Do you suffer from claustrophobia?	☐Yes	☐No
Is there any possibility you could be pregnant?	☐Yes	☐No
Are you breastfeeding?	☐Yes	☐No
Do you have an IUCD fitted?	☐Yes	☐No

I acknowledge to the best of my understanding the above answers are true and consent to the MRI scan.

Patient Signature: **Date:**

Form completed by: ☐Patient ☐Relative ☐Doctor ☐Other:

MRI Office Use Only
☐Correct Patient ☐Correct Procedure ☐Patient is MRI safe **Signature:**