NORTHCOAST IMAGING MRI SERVICES
MRI SAFETY PRE-SCREENING QUESTIONNAIRE

Name_____ Date_____

D.O.B_____ (DD/MM/YY) Gender: M / F Weight _____

Previous MRI: Yes / No If yes, Where_____

The following items may be harmful to you during your MRI scan or may interfere with the MRI examination. Please indicate whether or not any of the items below applies to you by ticking "Yes" or "No" for each item.

YES	NO	
☐	☐	Cardiac pacemaker or implanted cardioverter defibrillator/ICD
☐	☐	Internal electrodes or wires (pacing wires, DBS or VNS wires)
☐	☐	Artificial heart value, coil, filter and/or stent (Gianturco coil, IVC filter)
☐	☐	Aneurysm clip(s)
☐	☐	Neurostimulator-TENS Unit, Biostimulator, bone growth stimulator, DBS, VNS
☐	☐	Implanted drug pump (for chemotherapy medicine, pain medicine)
☐	☐	External drug pump (for Insulin or other medicine)
☐	☐	IV access port (Port-a-Cath, Broviac, PICC line, Swan-Gantz, Thermodilution)
☐	☐	Implanted post surgical hardware (pins, rods, screws, plates, wires)
☐	☐	Artificial joint and /or limb
☐	☐	Artificial eye and/or eyelid spring
☐	☐	Eye injury from a metal object (metal shavings, metal slivers)
☐	☐	Ear (Cochlear) implant, middle ear implant
☐	☐	Hearing aid(s)
☐	☐	False teeth/dentures, metallic removable dental work, braces, retainers
☐	☐	Have you ever been shot with a gun?
☐	☐	Injured by a metal object (shrapnel, bullet, BB) which required medical attention
☐	☐	Medication patch (nitroglycerine, nicotine, contraceptive, estrogen)
☐	☐	Shunt or Sophy adjustable and programmable pressure valve
☐	☐	Spinal fixation device, spinal fusion and/or halo vest, spinal cord stimulator
☐	☐	Surgical clips, staples or surgical mesh
☐	☐	Tissue expander (breast)
☐	☐	Penile implant
☐	☐	Pessary, IUD, Diaphragm
☐	☐	Radiation seeds (cancer treatment)
☐	☐	Body piercing, tattoo or permanent makeup
☐	☐	Wig, hair implants

Do you have a history of these conditions? Please indicate by ticking "Yes or No" for each item

YES	NO		YES	NO	
☐	☐	Kidney disease	☐	☐	Latex Allergy
☐	☐	Kidney transplant	☐	☐	Allergic reaction to MRI contrast
☐	☐	Single kidney			(Gadolinium based)
☐	☐	Kidney surgery	☐	☐	Drug Allergy, Type: _____
☐	☐	Diabetes			
☐	☐	Liver disease			
☐	☐	Claustrophobia			
☐	☐	Cancer **If YES**, please specify _____			

☐ ☐ Are you on dialysis? **If YES**, Hemodialysis or Peridialysis? (circle one)

☐ ☐ Have you had any major surgical procedures?

What type of surgery and when? _____

Female Patients:

YES	NO		YES	NO	
☐	☐	Is there any possibility of being pregnant?	☐	☐	Are you breast-feeding?

Date of LMP_____

If you answered YES to any of the questions on the front page, please discuss any concerns and/or issues you may have, with your MR Technologist.

Instructions for the Patient, Parent, Guardian:

1. Remove **ALL** jewelry, **ALL** body piercing jewelry and **ALL** hair accessories (hairpins, clips, etc).
2. Remove dentures (false teeth), partial dental plates, retainers (if removable).
3. Remove hearing aids and eyeglasses.
4. You will be required to remove **selected items** of clothing and asked to change into a gown.
5. We will provide a locker so that **ALL** items removed may be stored and locked safely during your scan. The locker key should be left with the technologist before entering the scan room.
6. You are advised to use the restroom before your MRI examination.
7. Please make sure that you receive a pair of earplugs before your MRI examination begins. These will help to protect the eardrums from the excessive noise.

I confirm that the above information is correct to the best of my knowledge. I have read and I understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form. I am satisfied that all possible precautions will be taken in regards of my safety.

_____ _____ _____

Patient/Parent/Guardian/Other Signature Date