Patient - MRI Safety Screening Form

The following questionnaire is designed to identify metallic items in the body that may cause harm if taken into the MRI scanner magnetic field.

You may also wish to read the Patient Information Leaflet 'MRI Examination'

You **must complete** this questionnaire before your appointment and contact the Radiology department if you answer **'Yes'** to any of the questions from **1 to 6**.

Failure to answer these questions correctly or to contact the department may result in a delay to your scan being carried out.

Your Details:

Surname: .....

Forenames: .....

Address: .....

.....

.....

Date of Birth: .....

Telephone Number: .....

Weight ..... **Height:** .....

Please sign this form on the back page on the day of your scan: By signing overleaf you acknowledge that you have had the MRI scan procedure explained to you by the Radiographer, that you have removed all metal objects (keys, coins, mobile phone jewellery etc.) and that you have answered the questions to the best of your knowledge.

Booking Staff Comments:

Booking Staff Name (only where applicable): Date:

....

QUESTIONS – please tick yes or no in the columns provided	**YES**	**NO**
1. Have you ever been fitted with a cardiac (heart) pacemaker or implanted defibrillator (ICD)? If YES, please describe:		
2. Have you ever undergone any surgery or other procedure to your heart? If YES, please describe:		
3. Have you ever had any of the following medical implants:		
Aneurysm clip		
Programmable hydrocephalus shunt		
Cochlear implant		
Neurostimulator		
Implantable drug infusion pump		
4. Have you **EVER** had any metal fragments in your eyes?		
If you answered Yes - did you seek medical advice and did a Doctor tell you everything had been completely removed?		
5. Have you had any other surgery to your head (including your eyes and ears) or to your spine? If YES, please describe:		
6. Have you had any operations that involved metal clips, pins, plates, stents or other medical implants or devices? If YES, please describe:		
7. Have you ever had any shrapnel (fragment of metal) injuries to the body?		
8. Have you ever suffered from epilepsy or have you ever had a fit/blackout?		
9. Have you had any operations in the last 6 weeks?		
10. Do you wear a medicine patch? (Fentanyl, nicotine, HRT etc)?		
11. Do you have any tattoos, permanent cosmetics or piercings?		
12. Female patients only: Is there any possibility of you being pregnant?		
If you have answered YES to any question from 1 to 6, please contact the MRI department		

Patient Signature: ..... **Date:** .....

Radiographer Signature: ..... **Date:** .....

Radiographer comments:

Side Identified with Patient: Left / Right (delete as applicable)