PATIENT MRI SAFETY QUESTIONNAIRE

NAME _____

DATE OF BIRTH _____ WEIGHT _____

Certain precautions need to be taken for your safety in Magnetic Resonance Imaging. Please answer the following questions by ticking the appropriate box.

	Yes	No	If yes, please give details.
Have you had an MRI scan before, if yes when and where?			
Do you have a cardiac pacemaker or Internal Cardiac Defibrillator?			
Do you have a loop recorder / reveal device?			
Do you have coronary artery stents (heart)?			
Have you had any heart surgery including valve replacements?			
Do you have aneurysm clips or a programmable shunt in your brain?			
Do you have a cochlear implants in your ear?			
Do you have a spinal cord stimulator or anything implanted in your spine?			
Do you have any stents implanted in your body ?			
Do you have any coils / filters / ports implanted in your body?			
Do you have any joint replacements /pins / plates / screws?			
Do you have an ocular implant?			
Do you have any type of electronic, mechanical or magnetic implant or device?			
Do you have any gastric band?			
Have you had metal fragments go into your eyes or body?			
Have you had ANY operations carried out in the last two months?			
Do you have any allergies?			
Do you suffer from blackouts / epilepsy?			
Do you suffer from diabetes?			
Do you suffer from angina / high blood pressure?			
Do you suffer from asthma / COPD?			
Have you got any glucose monitoring / medicine patches attached to your body or IUCD or a procedure involving swallowing a 'pillcam'			
Do you have any other significant current/past medical history?			
If applicable – Is there any chance you could be pregnant?			

Please remove piercings, eye makeup, loose metallic objects, watch, keys, coins and bank cards

By signing this form you are confirming:

- The above answers are correct.
- You consent to the Newcastle Clinic sharing your images with the reporting radiologist and your referrer.
- You understand your report will only be shared with you referring clinician.

Patient Signature _____

Radiographer Signature _____ **Date**_____