ST VINCENT'S HOSPITAL SYDNEY

MRI Safety Screening Questionnaire

Name:	Date of birth:	Male ☐
Weight (must be answered):	Height:	Female: ☐

Some implanted devices, implants or foreign bodies are NOT safe for MRI. To ensure your safety it is important that you answer the following questions accurately.

Please circle either YES or NO. Do you currently have or did you ever have any of the following

1. Cardiac Pacemaker/Defibrillator?	YES	NO
2. Artificial Heart Valve or annuloplasty ring?	YES	NO
3. Coronary Artery Stent/s?	YES	NO
4. Blood Vessel Stents/ IVC filter/ embolization coils?	YES	NO
5. Aneurysm Clips?	YES	NO
6. Implanted shunt?	YES	NO
7. Cochlear implant, stapes implants or other ear implant?	YES	NO
8. Neurostimulator, spinal stimulator or other electronic device?	YES	NO
9. Metal fragments in your eye (now or ever)?	YES	NO
10. Breast implant with access port or breast expander?	YES	NO
11. Gastric banding?	YES	NO
12. Implanted drug or infusion pump?	YES	NO
13. Magnetically activated implant or device?	YES	NO

If you have circled YES to any of the above then further information will need to be provided to the MRI department prior to your appointment.

Do you currently have any of the following items in on your body?

14. Recent endoscopy/colonoscopy clips (less than 6 weeks)?	YES	NO
15. Bone screws, nails or pins?	YES	NO
16. Shrapnel, bullets or foreign bodies?	YES	NO
17. Any dentures or prosthetic devices?	YES	NO
18. Metal body piercing or tattoos?	YES	NO
19. Dermal skin patches for drug delivery eg nicotine, oestrogen?	YES	NO
20. Intrauterine Contraceptive Device (IUD)?	YES	NO
21. Hair extensions / pins (must remove) or a wig?	YES	NO
22. Magnetic cosmetic devices (eyelashes, magnetic nail polish)?	YES	NO

PLEASE COMPLETE PAGE 2 OF OUR QUESTIONNAIRE.

ST VINCENT'S HOSPITAL SYDNEY

MRI Safety Screening Questionnaire Page 2

Please answer YES or NO

23. Could you be or are you pregnant?	**YES**	**NO**
24. Are you breast feeding?	**YES**	**NO**
25. Are you here for a MRI examination?	**YES**	**NO**
26. Do you have any medication allergies?	**YES**	**NO**
27. Have you had a previous MRI? If yes when:	**YES**	**NO**

Please list all operations/procedures you have EVER had:

Please tick the following to indicate that you agree:

- I will remove all metal from myself including keys, coins, piercings, jewellery, hearing aids, bobby pins etc before entering the room. (locker available in your change room) ☐
- I acknowledge that this form is accurate to the best of my knowledge, I have read and understood the questionnaire and I have had the opportunity to ask questions about this questionnaire. ☐
- I acknowledge that St Vincent's Hospital Medical Imaging Department has taken reasonable precautions and is not liable for any event that might result from incorrect answers on this form. ☐
- I consent to the MRI procedure that has been requested by my referring physician, including the injection of contrast if required. ☐

Print Name: ________________________________ **Signature:** ________________________________

Date: ______________________________________

For MRI staff use only:

MRI Timeout/Safety Checked by:

Timeout electronically recorded in the Radiology Information System.

Contrast details (agent/dose/authorizing Dr) recorded in the Radiology Information System.