MRI PROCEDURE SCREENING FORM

PERTH RADIOLOGICAL CLINIC

Surname: ..... **Given Name:** .....

Date of Birth: ..... **Weight:** .....

MRI is simple, safe and painless. However, because we use strong magnetic field, metal objects in or on your body may be hazardous to you and/or may cause interference. The MRI system is ALWAYS on. Please provide us with this important information BEFORE entering the MRI room.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING	**YES**	**NO**
Cerebral aneurysm clip or coil?	☐	☐
Pacemaker or implanted cardiac defibrillator (ICD)?	☐	☐
Heart surgery or heart valve? If yes, explain:	☐	☐
Ear surgery, cochlear implants, hearing aids or stapes prosthesis?	☐	☐
Eye surgery, implants, spring wires or retinal tack?	☐	☐
Any metal fragments in your eyes?	☐	☐
Electrical, mechanical or magnetic implants? Type:	☐	☐
Neuro-stimulator, bio-stimulator or bone growth stimulator?	☐	☐
Shunts, stents, filters or intravascular coil?	☐	☐
Vascular access port or catheter?	☐	☐
Any prosthesis or implant (IUD, joint replacement or penile implant)?	☐	☐
Implanted drug infusion pump or insulin pump?	☐	☐
Breast tissue expander?	☐	☐
Gunshot wounds or shrapnel?	☐	☐
Medication patches?	☐	☐
Are you or could you be pregnant?	☐	☐
Do you have pins in your hair or clothes, hair extensions, a hairpiece or wig?	☐	☐

TO HELP US PROVIDE A TIMELY AND RELEVANT REPORT PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Date of your next doctor's appointment .....
2. Have you had a previous scan of the area being scanned today? ☐ Yes ☐ No
   If yes, when and which radiology company/hospital .....
3. If you have had surgery/arthroscopy in the area being scanned please tell us when and what was done
   .....
   .....
4. Briefly describe your symptoms, including side and site of pain and/or numbness and date of onset
   .....
   .....
5. Presumed cause (eg. accident/injury/arthritis) .....
6. Please list general medical conditions (eg. diabetes/gout etc.) .....

I have read and understood the contents of this form.

Signature: ..... Signature: ..... Date: .....
(Patient/Guardian) *(Radiographer)*

If you have any questions, please ask the Radiographer before your examination.