VISIT DETAILS

MRI SAFETY SCREENING FORM

PERTH RADIOLOGICAL CLINIC

Surname: ..... Weight: .....

Given Name: ..... Height: .....

Date of Birth: ..... Contact Number: .....

CHECKED
- ☐ FULL NAME
- ☐ DOB
- ☐ EXAM PROT

Initial

MRI uses a strong magnetic field, metal objects in or on your body may be hazardous to you and/or may cause interference. The MRI magnet is **ALWAYS** on. Please provide us with the information below, we will use this information to determine your safety status to have an MRI scan.

IF YOU HAVE ANY QUESTIONS. PLEASE ASK THE RADIOGRAPHER BEFORE YOUR EXAMINATION.

Have you ever had any of the following in your body?	**CIRCLE ANSWER**	
Pacemaker or implanted cardiac defibrillator (ICD)	YES	NO
Neurostimulator or deep brain stimulator	YES	NO
Cochlear implant	YES	NO
Cerebral aneurysm clip	YES	NO
Implanted drug infusion pump or insulin pump	YES	NO
Shunts, stents, cardiac stents, filters or intravascular coil? *Type*	YES	NO
Electrical or magnetic implants? (e.g. Cardiac loop recorder, glucose monitor)	YES	NO
Ear Surgery, implants, hearing aids or stapes prosthesis?	YES	NO
Eye Surgery, implants, spring wires, scleral buckle or retinal tack?	YES	NO
Metal fragments in your eye(s)?	YES	NO
Breast tissue expanders	YES	NO
Do you have currently any of the following on your body?		
Medication patches, pins in your hair, hair extensions, wig, eye makeup?	YES	NO
Do you have ANY metal implants in your body? *If yes, please list all*	YES	NO
.....		
Have you ever had ANY surgery? *If yes, please list all*	YES	NO
.....		
.....		
Are you or could you be pregnant?	YES	NO

To help us provide a timely and relevant report please answer the following questions

Date of your next doctor's appointment?

Have you had previous imaging of the area being scanned? YES NO

If yes; when, what type of scan (e.g., MRI/CT/Ultrasound) and which radiology company/hospital

.....

If you have had surgery, in the region that we are scanning, please list what was done.

.....

.....

Briefly describe your symptoms, including side and site of pain and or numbness and date of onset?

.....

.....

.....

Presumed cause (e.g., accident/injury/arthritis) .....

Please list general medical conditions (e.g., diabetes/gout) .....

I understand that some implants and devices may cause significant harm to myself and others if brought into the scan room. I confirm that I understand and have carefully answered the above safety questions and consent to proceed with the MRI examination.

Signature: ..... Date: .....

RADIOGRAPHER CHECKED ☐

SIGNATURE

VISIT DETAILS

MRI CONTRAST INJECTION

PERTH RADIOLOGICAL CLINIC

What is an MRI contrast injection?

Your doctor has requested us to perform an examination requiring an injection of an MRI contrast agent. This is a routine and important part of some MRI examinations for accurate diagnosis. MRI contrast (dye) contains Gadolinium and is used to improve the visibility of the internal structures within the body. Without its use, significant abnormalities may go undetected.

What are the risks?

The contrast injection is considered safe for the majority of patients but, as with most drugs, side effects and adverse reactions are possible. You need to be informed of the risks, which may include:

1. Nausea, dizziness, headache, a metallic taste in the mouth, tingling in the arms/legs occurs in less than 1% (less than one in a hundred) of patients.
2. Insertion of the needle may cause minor pain, bruising and/or infection at the injection site.
3. Minor allergic reactions may occur. These usually consist of skin redness and itching (hives).
4. More severe reactions are rare but may result in difficulty breathing, facial swelling and low blood pressure.
5. It is extremely rare for reactions to be life threatening or severe (less than 1 in 300 000).
6. Recent studies have shown that a small amount of the injected dose of Gadolinium can be retained in several parts of the brain. The clinical significance of this is unknown, but currently no adverse effect has been proven. Wherever possible PRC will perform the MRI without contrast, except where it is thought to be important to the diagnosis.
7. You may at any point during the examination refuse the contrast injection.

Certain patients are at a higher risk for experiencing a reaction to Gadolinium contrast. It is important that you answer the following questions prior to receiving a contrast injection:

CIRCLE ANSWER

1. Are you receiving treatment for hypertension (high blood pressure)? **YES NO**
2. Do you have diabetes mellitus? (diabetes)? **YES NO**
3. Do you have poor kidney function or kidney disease (Including prior renal transplant or a solitary kidney)? **YES NO**
4. Have you had or are you waiting for a liver transplant? **YES NO**
5. Have you ever had a reaction to MRI contrast (Gadolinium)? **YES NO**
6. Are you pregnant or breast feeding? **YES NO**

If you have any concerns, please raise them with a staff member before you undergo your MRI examination.

Consent

I have read and understand the above information. I have carefully answered the questions and I give my permission for an MRI contrast injection.

.....
Patient Name

....
Patient Signature (or Legal Guardian) Date

Prostate, female pelvis and lower gastro intestinal tract MRI scans - *please read below and answer*

Hyoscine butylbromide (brand name Buscopan®)

As your bowel is constantly moving, this can make MRI images blurry. Buscopan® belongs to a group of medicines call 'antispasmodics', which means that it helps to slow down this movement and improves the quality of your MRI examination.

What are the risks?

Like all medicines, hyoscine butylbromide can cause side effect although not everybody will experience them. Some of the more common side effects include blurred vision, a dry mouth, dizziness, increased heart rate, constipation and pain at the injection site.

Serious side effects have been rarely reported. Please seek immediate medical attention if you have any of the following:

- allergic reactions such as skin rash
- severe allergic reactions such as difficulty breathing
- nausea and vomiting
- painful red eye with loss of vision

CIRCLE ANSWER

1. Are you allergic to hyoscine butylbromide (Buscopan®)? **YES NO**
2. Do you have a diagnosed heart arrhythmia or unstable cardiac disease? **YES NO**

OFFICE USE ONLY

Renal function

Date

Cr =
eGFR =

Buscopan Details

☐ 20mg/1ml IV Buscopan

Batch .....

Expiry .....

Contrast Details

☐ GADOVIST® IV

☐ PRIMOVIST® IV

OTHER .....

Volume

☐ 5 mLs ☐ 7.5 mLs Batch .....

☐ 10 mLs Other ..... Expiry .....

RADIOGRAPHER CHECKED ☐ SIGNATURE .....