Perth and Smiths Falls District Hospital

Department of Diagnostic Imaging – MRI
MRI Screening Form

An MRI Exam involves the use of a very strong magnet. For **YOUR SAFETY**, the presence of certain metallic objects must be determined **BEFORE** you enter the exam room. Please check the appropriate answer for each item listed.

If you answer YES to any implanted device, we must know who the manufacturer is and when it was implanted. If surgical reports are required, your test may need t be rebooked.

	YES	**NO**
1. Have you ever had an MRI exam? When? Where? What body part?		
2. Are you claustrophobic? (fear of confined spaces)?		
3. Are you taking a sedative for this MRI?		
4. Have you had any **heart surgery** and/or **Pacemaker or Defibrillator** inserted? **Please circle which one.**		
5. Do you have any **brain surgery** and/or **aneurysm clips? What? When?**		
6. Have you had surgery related to the body part being examined today?		
7. Do you have an epidural catheter implanted currently?		
8. Do you have any **ear or eye implants**? **Manufacturer Name? When?**		
9. Do you have any implantable pumps? (for insulin, pain or chemotherapy)		
10. Do you have a neurostimulator implanted or TENS device?		
11. Have you had a limb or joint replacement/pins/rods/screws?		
12. Have you ever had metal removed from your eyes, head, or body?		
13. Do you do any metal work? (mechanic, welder, machinist)		
14. Do you have tattoos or body piercing? **Please circle which one.**		

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	YES	NO
15. Do you have an intrauterine device or Pessary or Penile Implant? **Manufacturer Name? When?**		
16. Are you currently wearing a Medication patch or Glucose sensor?		
17. Have you had a colonoscopy or endoscopy in the last 2 weeks?		
18. Do you wear any removable dental work, or hearing aids? **Please circle which ones.**		
19. Do you have allergies?		
20. Have you EVER had any kind of **gastric (stomach or intestinal) surgery? What was done and when?**		
21. Do you have kidney problems and/or Dialysis and/or Renal Failure		
22. Have you ever had a reaction to MRI Contrast Media?		
23. Do you have any **shunts, stents, Filters or surgical clips** in your body?		
24. Any possibility of pregnancy? Date of last menstrual period?		
25. Are you breast feeding?		

Please remove the following items before you exam:

Wig or Hair piece	Jewelry	Wallet/Money clip/Coins
Medication patch	Eyeglasses	Credit cards/ATM cards
Watch/Keys	Hearing aides	Safety pins
Bobby pins/Hair clips	Bra/Girdle	Removable dentures

The following is required for this test:

Weight _____lbs/Kg and Height _____Ft/m

_____	_____	_____
Date (yy/mm/dd)	**Patient name (print)**	**Patient signature**
_____	_____	_____
Date (yy/mm/dd)	**Technologist name (print)**	**Technologist signature**