THE ALFRED

MRI SAFETY SCREENING

U.R.	
Surname	
Given Names	

To ensure your safety and comfort please complete the questions on both sides of this document and sign in the space provided:

WEIGHT: _____ kg **HEIGHT: _____cm**

HEAD

Have you ever had?

- Aneurysm or AVM clips in the brain ☐ YES ☐ NO
- Brain or spinal CSF shunt ☐ YES ☐ NO
- Penetrating eye injury involving metal ☐ YES ☐ NO
- Eye surgery involving implants (e.g. eyelid spring, retinal tack) ☐ YES ☐ NO
- Cochlear implant or middle ear surgery (e.g. Stapedectomy) ☐ YES ☐ NO
- Any other head or brain surgery ☐ YES ☐ NO

Please describe……
……

HEART

Have you ever had?

- Cardiac Pacemaker, Implanted Defibrillator (ICD) or pacing wires ☐ YES ☐ NO
- Heart valve repair or replacement ☐ YES ☐ NO
- Other heart surgery or implant (e.g. bypass surgery, 'hole in the heart', loop recorder) ☐ YES ☐ NO

Please describe……
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COILS, STENTS, FILTERS

Have you had any of these devices inserted?

- Embolisation coils ☐ YES ☐ NO
- Inferior Vena Cava (IVC) filter ☐ YES ☐ NO
- Stents ☐ YES ☐ NO
- Any other surgery or procedure to repair your blood vessels? ☐ YES ☐ NO

Please describe……
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ELECTRONIC, MAGNETIC & MECHANICAL DEVICES

- Do you have an Insulin pump? (internal or external) ☐ YES ☐ NO
- Any other drug infusion pump? ☐ YES ☐ NO
- Neurostimulator or bone fusion stimulator? ☐ YES ☐ NO
- Penile implant? ☐ YES ☐ NO
- Any other mechanical, electronic or magnetic device? ☐ YES ☐ NO

Please describe……
……

GASTROINTESTINAL

Have you ever had any of these procedures?

- Pillcam capsule ☐ YES ☐ NO
- Metal clips in stomach/bowel from endoscopy (gastroscopy or colonoscopy) ☐ YES ☐ NO
- Any other stomach or bowel surgery (e.g. PEG tube, lap band or gastric banding) ☐ YES ☐ NO

Please describe……
……

Please call us 9076 0357 if you have answered 'yes' to any of the above questions and you have not had an MRI scan at the Alfred since the device was implanted.

OTHER IMPLANTS

Do you have any of the following?

- Joint replacement or prosthetic limb? ☐ YES ☐ NO
- Metal plates, rods or screws in bone? ☐ YES ☐ NO
- Metal staples, clips or mesh in soft tissue? ☐ YES ☐ NO
- Harrington rods or other spinal surgery? ☐ YES ☐ NO
- Vascular access port (eg. Portacath)? ☐ YES ☐ NO
- Bullets, shrapnel or other metallic foreign body? ☐ YES ☐ NO
- Any other metallic implant? ☐ YES ☐ NO

Please describe……
……

MR
E71(IP)
W71(OP)

- Do you have any of the following (please circle)

  Dentures / Dental braces / Hearing Aids / Tattoos / Permanent makeup / Medicated skin patch

- Are you claustrophobic? □ YES □ NO

What is your current problem? (Have you had any surgery for this?)

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FEMALE PATIENTS

- Is there a chance you are pregnant? □ YES □ NO
- Are you currently breastfeeding? □ YES □ NO

Please call us on 9076 0357 if you answer "Yes" to either of the questions above

- Do you have an IUD, diaphragm or pessary? □ YES □ NO
- Do you have breast implants or a breast tissue expander? □ YES □ NO

CONTRAST MEDIA

An injection of contrast may benefit for your MRI examination. Please answer these questions in case it is required.

- Are you diabetic? □ YES □ NO
- Have you ever had any kidney disease? □ YES □ NO
- Do you have multiple myeloma? □ YES □ NO

If you answer 'yes' to any of these questions please call us on 9076 0357 and provide us with details of your most recent blood test (when & where).

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- Have you previously had an allergic reaction to MRI contrast? (when & where?) □ YES □ NO

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Patient Signature (or Person Responsible): _____ **Date:** _____

Name of Person Responsible (if applicable): _____ **Relationship:** _____

FOR INPATIENTS ONLY– MUST BE COMPLETED BY REFERRING MEDICAL STAFF OR PRIMARY NURSE

Does your patient have?

- External fixation or a Halo Vest □ YES □ NO
- ICP Monitoring (Codman's) □ YES □ NO
- Cardiovascular Catheter (Swan-Ganz) □ YES □ NO
- Skin dressings containing silver □ YES □ NO
- Was your patient able to fill out this form unassisted? □ YES □ NO

If not, why? ……

Transport requirements: Bed / Wheelchair / Nurse Escort / Spinal Precautions / Intubated / Isolation / Suction

Please remove all ECG electrodes, temperature probes from catheters and disconnect all infusions if possible.

Contact MRI on ext 68844 if you believe your patient will require pain relief or sedation

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MRI use only

Checked by: _____ (MRI Radiographer) Date: _____

Interpreter Used: □ YES □ NO Language: _____

Screening x-rays reviewed and approved by (if necessary): _____ (Radiologist)

Notes:

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