MRI Safety Questionnaire

It is essential for patient safety that you complete this form as accurrately as possible

For further information contact MRI on 9231 3056

ST VINCENT'S MRI CENTRE

A SERVICE OF ST VINCENT'S HOSPITAL MELBOURNE

SECTION A **DO YOU HAVE ANY OF THE FOLLOWING?**

Medical Conditions?	YES	NO
Heart Disease		
Liver Disease		
Kidney Disease		
Diabetes		
Epilepsy		
Sickle Cell Anemia		
Allergies		
If YES, to what?		

Implanted Cardiovascular Devices?		
Cardiac Pacemaker		
Cardiac Defibrillator		
Cardiac Monitor / Recorder		
Prosthetic Cardiac Valve		
Aneurysm or Vascular Clips		
Embolization Coils		
Stent or Filter		

Implanted Neurological Devices		
Neurostimulator		
Brain or Spine Shunt		
If YES, is it Programmable?		

Gastrointestinal Tract Procedures or Devices		
Swallowed a Pill Cam in last 12 months		
Colonoscopy/Polyp Removal in last 2 months		
Lap Band		

Other Implants etc?	YES	NO
Implanted Drug Infusion Device		
Drug patch		
Inner Ear Implant		
Hearing Aid		
Intrauterine Contraceptive Device (IUD)		
*If YES, what type?*_____		
Penile Implant		
*If YES, what type?*_____		
Breast: Expander, Implant, Biopsy Clips		
*If YES, what type?*_____		
Joint Prosthesis		
Stents: bilary, renal		
Wire sutures		
Other Metal Implants: Pin, Plate, Screw		

Other Foreign Bodies/Materials/Devices?		
Removable Dental Appliances		
Body Piercing or Jewellery		
If YES, have they been removed?		
Tattooed Eyelids		
Shrapnel or Bullet		
Other:		

SECTION C

Weight:

Height:

eGfr:

SECTION B

	YES	NO
ARE YOU PREGNANT, OR SUSPECT THAT YOU MAY BE PREGNANT?		
*If YES, how many weeks?*_____		
HAVE YOU EVER HAD AN INJURY INVOLVING METAL TO YOUR EYE?		
If YES, is there Metal Fragment still in the Eye?		
HAVE YOU EVER HAD BRAIN, EYE, EAR, HEART OR VASCULAR SURGERY?		
If YES, what type?		
HAVE YOU EVER HAD ANY OTHER OPERATIONS/SURGICAL PROCEDURES?		
If YES, what type?		

PLEASE BRING ANY RELEVANT RADIOLOGICAL STUDIES (if not performed at St Vincent's)

X-ray	CT scan	MRI scan	Ultrasound	

Patient's Name (print):

Signature: Date:

STAFF use only

Checked By (print) MIT / RN / DR

Signature: Date:

By signing this form you confirm that the information provided has been reviewed with the patient or their next of kin/carer and has been answered competently and accurately.