Capital Health

Diagnostic Imaging Department
Patient Safety Screening Form for MRI Procedures

Patient's Name: _____

Date of Birth: _____ Weight: _____ Height: _____

Please answer all questions by selecting NO or YES. If you are in doubt, answer YES and we will investigate further. **We ask these questions for your own safety; providing incorrect information could have serious medical consequences.**

NO	YES	
☐	☐	Have you had a previous MRI exam?
☐	☐	Have you ever had MRI dye?
☐	☐	If you are a female, is there any chance that you may be pregnant?
☐	☐	Are you breast feeding?
☐	☐	Have you ever had an injury of any kind from a metal object such as a bullet, BB, shrapnel, or metal shavings?
☐	☐	Have you ever had metal in your eye?
☐	☐	Do you have glaucoma?
☐	☐	Are you on dialysis?
☐	☐	Do you have a history of kidney disease?
☐	☐	Do you have a latex allergy?

Please indicate if you have any of the following devices in or on your body:

☐	☐	Cardiac Pacemaker or defibrillator.
☐	☐	Neuro or Biostimulator.
☐	☐	Cerebral Aneurysm clips.
☐	☐	Any surgical clips or staples.
☐	☐	Have you had eye surgery i.e. detached retina or other?
☐	☐	Any type of implanted device such as a coil, filter, stent, surgical mesh, pins, etc.
☐	☐	Implanted drug pump for insulin, chemotherapy, pain medication, etc.
☐	☐	Transdermal patch for nitroglycerine, nicotine, hormones, etc.
☐	☐	Orthopaedic appliance such as a hip, knee replacement, or artificial limb.
☐	☐	Cochlear, or any type of ear implant, or ear surgery.
☐	☐	Hearing aid.
☐	☐	Removable dentures, plates or false teeth.
☐	☐	Tattoos or tattooed eyeliner.
☐	☐	Body pierced or other jewellery.
☐	☐	Wig or hair accessories.
☐	☐	A watch or any other loose metal objects such as coins.

Patient's/Other Signature: _____ Date: _____

MRI Technologist's Signature: _____

A different today. A better tomorrow.