St. Joseph's Healthcare Hamilton

IMAGING RESEARCH CENTRE SCREENING FORM

Patient Name: _____ Weight: _____

These Safety Questions must be answered by the patient:
Circle Yes or No to all questions:

1. Have you had a previous MRI?	Yes	No
2. Have you ever had a metallic foreign body in your eye that was not completely removed?	Yes	No
3. Are you claustrophobic requiring sedation?	Yes	No
4. Could you be pregnant?	Yes	No
5. Do you use any physical aids? (Walker, Cane, etc.)	Yes	No

Do you have any of the following?:

6. Pacemaker/defibrillator?	Yes	No
7. Cardiac Stent?	Yes	No
If yes, Year/Hospital _____		
8. Brain Aneurysm clip?	Yes	No
9. Ear/Cochlear Implant?	Yes	No
10. Neurostimulator or infusion pump?	Yes	No
11. Shrapnel/Bullets?	Yes	No
12. Other implanted device?	Yes	No

Please provide details of implant (e.g. type of implant, year implanted):

_____

_____

Have you ever had surgery on your (provide details):

Head or Neck? _____	Yes	No
Spine? _____	Yes	No
Chest/Abdomen/Pelvis?_____	Yes	No
Arms/Legs?_____	Yes	No

The above information is correct to the best of my knowledge. I have read and understood the entire content of this form and have had the opportunity to ask questions regarding the information on this form.

Patient Signature: _____ Date: _____