MRI Safety Questionnaire

Phone: 9600 9552 Fax: 9602 8386

PATIENT'S NAME_____ Patient #_____ DOB_____ M / F

Please circle YES or NO to each question below

Do you have a…	Pacemaker / Defibrillator?	YES	NO
	Neurostimulator?	YES	NO
	Cochlear implant?	YES	NO
	Aneurysm clip / Coil?	YES	NO

1. Do you have any metallic implants? YES NO
   If so, what ?
2. Have you been shot or had a shrapnel injury?……. YES NO
3. Have you ever worked with metal ?…… YES NO
4. Have you ever had metal in your eye?…….. YES NO
5. Have you had a MRI examination in last 12 months? YES NO
   If so, when and where……
6. Do you suffer from claustrophobia YES NO
7. Have you ever had kidney problems? YES NO
8. Do you have any allergies? YES NO
9. Have you had any surgery? YES NO
   If so, what type and when.....
10. Do you wear Dentures? YES NO
11. What is your current weight?.....

FEMALE PATIENTS

12. Are you pregnant or is there any chance you are pregnant? YES NO
13. Are you breastfeeding? YES NO
14. Are you using a Intrauterine Contraceptive Device? YES NO

I attest that the above information is correct to the best of my knowledge. I have read and understood the contents (nature and the preparation for the MRI examination) of this form.

I consent to the administration of ***contrast*** if it is required for the examination.

Patient Signature……..……..…… Date……

Contrast Administered……mL…… Radiographers Signature…….