

MRI Safety Screening Form

Family Name:		Given Name:	
MRN:		D.O.B	
Address			
Weight (Kg):		Height (cm):	

A booking has been made for an MRI scan at Research Imaging NSW on:

Date: _____ Time: _____

Please email this completed form to the study coordinator. Please also bring this form with you to your appointment.

The MRI Scanner has a very strong magnetic field that is ALWAYS ON. It can be hazardous to all individuals entering the MRI room with certain metallic, electronic, magnetic or mechanical devices, implants or objects. All individuals are required to fill out and sign this form BEFORE entering the MRI room.

Please answer the following questions and if you answer yes to anything in questions 1 - 3 or you do not understand any of the questions, please contact the MRI unit at safety.researchimaging@unsw.edu.au

1. Please indicate if you have any of the following:

Cardiac pacemaker / defibrillator	<input type="checkbox"/> yes <input type="checkbox"/> no	Shrapnel Injury	<input type="checkbox"/> yes <input type="checkbox"/> no
Aneurysm clip / coil	<input type="checkbox"/> yes <input type="checkbox"/> no	Magnetic Implant	<input type="checkbox"/> yes <input type="checkbox"/> no
Neuro-stimulator	<input type="checkbox"/> yes <input type="checkbox"/> no	Any Metal Implant (knee, hip)	<input type="checkbox"/> yes <input type="checkbox"/> no
Cochlear / Stapes implant	<input type="checkbox"/> yes <input type="checkbox"/> no	Any other metal in or on the body	<input type="checkbox"/> yes <input type="checkbox"/> no
Vascular implants	<input type="checkbox"/> yes <input type="checkbox"/> no	Any other implant _____	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart Valve replacement	<input type="checkbox"/> yes <input type="checkbox"/> no	Body / Eye tattoos / Piercings	<input type="checkbox"/> yes <input type="checkbox"/> no
Implanted mechanical /magnetic device	<input type="checkbox"/> yes <input type="checkbox"/> no		
Drug infusion device / Patches	<input type="checkbox"/> yes <input type="checkbox"/> no		
Surgical clips	<input type="checkbox"/> yes <input type="checkbox"/> no	Are you Claustrophobic?	<input type="checkbox"/> yes <input type="checkbox"/> no

2. Have you ever had an injury to the eyes involving a metallic object or fragment? (e.g. welding accident or shrapnel) yes no

(if yes plain orbit radiographs may be required prior to the MRI examination)

3. Are you or could you be pregnant? yes no

4. Have you had any operations or surgery? yes no

If Yes, please give details. Include details of implanted item make and model numbers if possible

Surgery: _____ Date: _____

5. Have you ever had an MRI scan before? yes no

Date: _____ Type: _____ Location: _____

If you are concerned about anything on this form, please consult the MRI Radiographer before you enter the MRI scanner room. I confirm that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Name:		Signature:		Date:	
Reviewed By:		Signature:		Date:	
Reviewer Designation:					