

Everyone must complete the following questionnaire prior to MRI scan

# MRI Safety Screening Form

Subject Information (Fill in at time of scan only)			
LAST NAME:		FIRST NAME:	
For staff or contractor, indicate your company & profession:			
DATE OF BIRTH		HEIGHT <input type="checkbox"/> cm <input type="checkbox"/> ft' in"	WEIGHT <input type="checkbox"/> kg <input type="checkbox"/> lbs
YYYY	MM	DD	

Subject Study ID

**Your safety is very important to us. Please complete the following to help us keep you safe.  
If you need help filling out the form, please let a staff member know.**

The MRI scanner is a very strong magnet. It might be unsafe if you have had surgeries with certain metal or electronic implants. For the MRI scan, you must remove all body piercings, hair accessories, jewelry, hearing aids, credit cards, coins, and other metallic or electronic personal items (watches, phones, etc.). Please tell us if you cannot remove any of these items.

To keep you as safe as possible, you must wear a hospital gown. You must remove undergarments that are not 100% cotton or cotton/polyester blend. Athletic undergarments can have metallic fibres and could cause a skin burn.

We provide you with a locker to secure your belongings.

List <u>all</u> previous surgeries and approximate dates (if you require more space, please let a staff member know):  <input type="checkbox"/> No surgery of any kind	List <u>all</u> allergies:  <input type="checkbox"/> No known allergies
List any medical procedures in the last 6 weeks (include <b>tattoos, injections, biopsies, colonoscopies, acupuncture</b> ):  <input type="checkbox"/> No medical procedures in last 6 weeks	

Tell us about any implanted medical devices or other possible hazards that could affect the MRI Scan:

IMPLANTED MEDICAL DEVICES		YES	NO	OTHER POSSIBLE HAZARDS		YES	NO
1	Stents, filters or coils			1	Injury to your eye from a metal object		
2	Heart valve			2	Injury by metallic object (bullet, shrapnel, etc.)		
3	Brain aneurysm clip			3	Hearing aid(s)		
4	IV access (Broviac, Port-a-Cath, Hickman, PICC, etc.)			4	Dentures. Dental retainers, braces or implants		
5	Pacemaker, defibrillator or leads (in-place or removed)			5	Hair accessories (wig, extensions, pins, barrettes, clips)		
6	Neurostimulator or biostimulator (in-place or removed)			6	Body piercings		
7	VP shunt			7	Tattoos or permanent makeup		
8	IUD, diaphragm or pessary			8	Magnetic eyelashes		
9	Metal rods, pins, screws or joint replacements			9	Medication patch		
10	Prosthesis (eye, limb, penile, etc.)			10	Glucose monitoring sensor		
11	Cochlear (middle ear) implant			11	On dialysis		
12	Eye implant, eyelid spring or wire			12	Breastfeeding		
13	Electronic device or implant (pill cam, infusion pump, etc.)			13	Known or possible pregnancy		
14	Breast tissue expander			14	Claustrophobia: <input type="checkbox"/> No <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		

If **Yes** to any of the above, please provide a short description of each:

**I confirm that I have read this form completely and that the information I have provided is accurate to the best of my knowledge.**

Completed by:	IF FORM NOT COMPLETED BY PATIENT, INDICATE RELATIONSHIP:	DATE
		YYYY   MM   DD

### Staff Comments:

LEVEL 2 MR-PERSONNEL WHO PERFORMED SCREENING:	DATE
	YYYY   MM   DD