MRI Safety Screening Questionnaire

MRI, unlike other methods of imaging the body, does not use radiation but rather uses magnetism and radio waves. Extensive evaluation has shown no long term adverse side effects related to MR imaging. However, the magnetic field can cause problems for patients with metallic implants and can damage certain items, so please do not take watches, hearing aids, electronic pagers, credit cards and such like into the scanner. If in doubt, please ask. The following questionnaire is designed to identify metallic items in the body that may be susceptible to magnetic fields.

You cannot have a scan if you have:

• A cardiac (heart) pacemaker
• Certain clips in your skull from brain operations e.g. aneurysm clips
• A cochlea (ear) implant
• A neuro-stimulator
• A metallic foreign body in your eye
• A programmable shunt for hydrocephalus (fluid on the brain)

Surname: .............................................................. Forenames: ............................................

Address: ............................................................................................. ....................................

.............................................................................. Date of Birth: ............................................

Telephone Number: .............................................. Patients Weight: ......................................

Please answer the following questions, which relate to metallic objects that may be present in the body

1. Do you have a cardiac (heart) pacemaker? YES / NO
2. Have you ever had any other surgery to your heart? YES / NO
3. Have you EVER had any metal fragments in your eyes? YES / NO
   If Yes, did you see a doctor or get medical advice? YES / NO
   If Yes, did a doctor tell you everything had been completely removed? YES / NO
4. Do you have a programmable hydrocephalus shunt? YES / NO
5. Do you have a cochlear (ear) implant? YES / NO
6. Have you had any operations on your head? YES / NO
7. Have you had any operations on your spine (neck or back)? YES / NO
8. Have you ever had any shrapnel (fragment of metal) injuries to the body? YES / NO
9. Have you had any operations that involved metal clips, pins, plates or implants? YES / NO
10. Have you had any operations in the last three months? YES / NO
11. Do you suffer from epilepsy or have you ever had a fit/blackout? YES / NO
12. Do you wear a medicine patch? (Nicotine, contraception angina patch etc)? YES / NO
13. Do you have any tattoos, permanent cosmetics or piercings? YES / NO

Female patients only

14. Are you, or could you be, pregnant? YES / NO
15. Are you breast-feeding? YES / NO

If you have answered "YES" to any of the questions above, please inform the appointments team or MRI department as soon as possible.

By signing below you acknowledge that you have had the procedure explained to you by the radiographer and you have answered the above listed questions.

Patients Signature (or Guardians): ............................................... Date:.....................

Radiographers Signature: .......................................................... Date:.....................