MRI SAFETY SCREENING QUESTIONNAIRE

Government of South Australia
SA Health

SOUTH AUSTRALIA MEDICAL IMAGING

OUTPATIENTS ONLY: *If you have answered 'yes' to an implant, please phone the MRI department to discuss. Booking of examinations will not commence until this form is completed, returned and implant details verified.*

Height (cm):

Weight (kg):

[AFFIX PATIENT LABEL HERE]

Have you ever had an MRI before?		Yes	No
Have you had any imaging related to your presentation? Please complete 'Further Details' below.		Yes	No
Have you had an operation in the last six weeks? Please complete 'Further Details' below.		Yes	No
HAVE YOU EVER HAD ANY OF THE FOLLOWING? If yes, complete 'Further Details' section below			
HEAD	Brain shunt? If programmable, mention in 'Further Details' section below.	Yes	No
	Aneurysm clip / Flow diverter / Embolization Coil?	Yes	No
	Ear implant? (Cochlear / Stapes)	Yes	No
	Eye implants? (Eyelids weights / Springs / Retinal tacks / Scleral buckle)	Yes	No
HEART	Cardiac pacemaker / Defibrillator / Pacing wires / Loop recorder?	Yes	No
	Artificial heart valve(s)?	Yes	No
VESSELS	HEART stents (Coronary artery stents)?	Yes	No
	Stents / Embolization Coils OUTSIDE the heart? (Abdominal Aortic Aneurysm (AAA) stents / Grafts)	Yes	No
	Inferior Vena Cava (IVC) filter?	Yes	No
	Vascular access port / Infusaport / Continuous glucose monitor?	Yes	No
OTHER	Orthopaedic metal work? (Joint replacement, or Screws / Plates / External fixators for broken bones)	Yes	No
	Prosthesis / Artificial body part?	Yes	No
	Neurostimulator / Bladder stimulator / Bone stimulator / Drug infusion device / Pain pump?	Yes	No
	Gastric banding?	Yes	No
	Breast implants? If expanders or readable chip present, include in 'Further Details' section below.	Yes	No
	Penile prosthesis / Urological implant?	Yes	No
	IntraUterine Device (IUD)?	Yes	No
	Permanent make-up / Tattoos / Piercings?	Yes	No
	Medication patches or silver impregnated dressings (for example Acticoat-7) on your skin?	Yes	No
	Any other implants or devices in or on your person not mentioned above?	Yes	No
ARE ANY OF THE FOLLOWING APPLICABLE TO YOU? If yes, complete 'Further Details' section below			
Have you ever had an eye injury involving metal?		Yes	No
If you have had an eye injury involving metal? If yes, include medical attention for removal in 'Further Details'?		Yes	No
Have you ever been injured by a metallic projectile or foreign body (BB / Bullet / Shrapnel)?		Yes	No
Are you, or is there any possibility that you could be, pregnant?		Yes	No
Are you breast feeding?		Yes	No
Do you have a family history of Liver disease / Kidney disease / Dialysis / Liver OR Kidney transplant?		Yes	No
DO YOU HAVE A HISTORY OF:	Liver disease / Kidney disease / Dialysis / Liver OR Kidney transplant?	Yes	No
	Allergies or eczema? If yes, include in 'Further Details' section below.	Yes	No
	High blood pressure / Diabetes / Heart disease / Stroke?	Yes	No
	Smoking?	Yes	No
Are you of Aboriginal / Torres Strait Island / Maori / Pacific Island ethnicity?		Yes	No
Are you claustrophobic?		Yes	No
Have you been given sedative medication to take prior to your scan? *Sedation is not provided to outpatients*		Yes	No

FURTHER DETAILS

If you answered 'Yes' to **ANY** questions above, please provide further information. For medical devices, be sure to include **make, model, hospital where device was implanted** and **year of implantation**.

NOTE: Medical device details below must be supported by further documentation before scanning can occur.

THE FOLLOWING ITEMS MUST BE REMOVED BEFORE ENTERING THE SCAN ROOM

Dentures, Heading Aids, Watches, Jewellery, Wallet, Coins, Credit Cards, Keys, Hair Clips, Pens, Glasses, Vapes

I declare that the above questions are answered to the best of my knowledge (circle as appropriate):

Signature of patient (16 and over) / parent / guardian / person responsible:_____ Date:_____

If not the patient: Name:_____ Relationship to patient:_____

Radiographer Signature: _____ **Suitable to scan at:** ☐ **1.5T** ☐ **3T** ☐ **Both**

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[AFFIX PATIENT LABEL HERE]

FOR TREATING DOCTOR

PATIENT UNABLE TO COMPLETE THEIR QUESTIONNAIRE

If the patient (or parent / guardian / person responsible) is unable to complete their MRI safety screening questionnaire, it must be filled in by the treating doctor, using information obtained from a relative, or person who knows the patient's full medical history.

In the event no suitable person known to the patient can be contacted, please answer questionnaire using the medical record and medical imaging clearance using CT head, CXR & AXR will be required. MRI staff will contact the treating doctor if there is the need for them to request new imaging.

Prior to scanning: Remove ALL ECG dots, leads, monitoring devices and catheters with temperature probes. If intravenous (IV) contrast is required, a cannula is needed.

Reason for inability to complete safety questionnaire (please circle):

Stroke / Confusion / Decrease Consciousness / Language Barrier / Cognitive / Hearing / Memory

Other:_____

The questionnaire has been completed BY (Treating doctor):

Name: _____ Phone Number: _____

Signature: _____ Date: _____

The questionnaire has been completed with information FROM:

Name: _____ Phone Number: _____

Connection to patient undergoing examination:

☐ Close family member Relationship:

☐ Patient's GP Length of time that the patient has been seeing their GP: _____

☐ Interpreter Language: _____

Does the patient require an interpreter or family member present for their MRI scan: Yes No

[RADIOLOGY USE ONLY] Imaging clearance – minimum imaging required: CT head, CXR & AXR

Patient's MRI scan has been approved by:_____(radiologist)

The questionnaire has been completed by reviewing previous imaging (including private providers) or asking the referrer to request new imaging and reviewing the new imaging:

CT head Date:_____Metal seen? Yes☐:_____ | No☐

CXR Date:_____Metal seen? Yes☐:_____ | No☐

AXR Date:_____Metal seen? Yes☐:_____ | No☐

Other imaging: Date:_____Metal seen? Yes☐:_____ | No☐

Signed: _____Date:_____

Name:_____Contact details:_____

	Royal Adelaide Hospital	Flinders Medical Centre	Lyell McEwin Hospital	Women's and Children's Hospital	The Queen Elizabeth Hospital	Riverland General Hospital
Phone:	707 44020	820 45750	818 29584	816 17447	822 26894	858 02430
Fax:	707 46196	820 45790	818 29998	816 16969	822 26040	858 02440

ECG = electrocardiogram, CT = computed tomography, CXR = chest X-ray, AXR = abdominal X-ray, GP = general practitioner
BMI = body mass index, DOB = date of birth, URN = unit record number