

3T MRI - PATIENT SAFETY QUESTIONNAIRE

SURNAME: _____ FIRST NAME: _____ DOB: _____
 ADDRESS: _____
 EMAIL ADDRESS: _____ TELEPHONE: _____

Certain implants, devices and objects may be hazardous to you or may interfere with the MRI examination
 Please answer YES or NO to the following list of questions for your safety

HAVE YOU EVER HAD:			DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING: List A				
Brain Surgery	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Cardiac Pacemaker or Implanted Defibrillator	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
Heart Surgery	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Brain Coiling or Aneurysm Clip	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
Heart Stents	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Cochlear Ear Implant / Stapes Ear Implant	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
Artificial Heart Valve	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Neurostimulator Implant	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
Ear Surgery	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Ventricular Brain Shunt	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
MRI Scan in the Past	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Drug Pump / Monitor (Insulin, Pain medicine)	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
Metal Fragments in Your Eyes	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Implanted Cardiac Monitoring System (Reveal LINQ)	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
<i>if yes was it all removed by a doctor?</i>	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Cardiac Closure Device for Hole in Heart Repair	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
DO YOU HAVE ON YOUR BODY:							
Artificial Limb	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Eye Prosthesis Containing Metal	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
Hearing Aids	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Breast Reconstruction Tissue Expanders	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
Dentures / Dental plates	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Invisible Implanted Hearing Aids (eg Lyric)	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
Wig / Hairpiece / Clip-in Hair Extensions	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Joint Replacements Less than 6 Weeks Post Op	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
Nicotine / Medicine Patch on Your Skin	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Pins/Plates/Screws/Rods Less than 6 Weeks Post Op	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
Electronic Devices Attached	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Operations in Last 6 Weeks with Metal Clips Inserted	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
Coloured Contact Lenses	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Shrapnel, Metal Fragments or Bullet Injury	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
Dressings / Strapping Tape / Plasters	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Cosmetic Facial Tattoos	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
Body Piercings	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Recent Body Tattoos That are Not Fully Healed	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
<i>Please remove ALL piercings prior to coming for your scan</i>			IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE List A QUESTIONS YOU MUST CONTACT TARANAKI RADIOLOGY TO DISCUSS BEFORE WE CAN BOOK YOU IN FOR YOUR MRI SCAN				
PREGNANCY / BREASTFEEDING / CONTRACEPTIVE DEVICES			Please Call 06 7594317 and Write Details Below:				
Any Possibility You Could Be Pregnant	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	LIST YOUR IMPLANTS / ADDITIONAL INFORMATION HERE:			
<i>(if yes please contact Taranaki Radiology on 06 7594317)</i>							
Are You Currently Breastfeeding	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>				
IUD/Mirena Coil/Contraceptive Device	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>				
CLAUSTROPHOBIC PATIENTS:							
Are You Claustrophobic	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>				
<i>if yes please contact Taranaki Radiology on 06 7594317</i>							

I attest that the above information is correct to the best of my knowledge. I have read and understand the questions:

Signature of Patient / Guardian / Other: _____ Date: _____

Please return this completed form to: Taranaki Radiology, MRI Magnet House, 59 Vivian Street, New Plymouth OR Scan form and email to bookings@taranakiradiology.co.nz

STAFF USE ONLY:

Questionnaire checked by MRI staff member: _____ Height: _____ CM.

Area to be scanned confirmed: _____ Weight: _____ KG.