RESEARCH IMAGING NSW

HC No: HC200919

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