

Outpatient MRI Safety Questionnaire

Radiology Department

Patient Name: _____
UR Number: _____
DOB: _____

Height: _____
Weight: _____
Exam Date: _____

Please complete the following MRI safety questionnaire. Please answer these questions carefully. **Answering incorrectly may be very harmful to your health.**

If you answer YES to any questions, fill in the attached PATIENT IMPLANT CONSENT FORM and return it to the Department of Radiology as Soon as Possible via

FAX (03) 9496 9462 or Email: enquires.radiology@austin.org.au or

Mail: MRI Radiology, Austin Health, PO Box 555, Heidelberg, VIC 3084

For Safety reasons, **failure to complete** these forms prior to your appointment may result in **DELAYS or CANCELLATION** of your appointment

Please indicate if you have any of the following:

- | | | |
|--|------------------------------|-----------------------------|
| Cardiac pacemaker or defibrillator | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Neurostimulator or other electronically activated device | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| A retained cardiac pacing wire or lead from a previous electronic device | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Prosthetic heart valve replacement or cardiac occluder/closure device | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cerebral (brain) aneurysm clip | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cochlea or inner ear implant | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Ocular (eye) prosthesis or implant | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Stent, IVC filter or embolisation coils | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Intra-ventricular (brain) or spinal shunt | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Joint replacement, pins, plates or screws | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| An implanted drug infusion device | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Breast tissue expander or penile implant | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Tattoo, permanent make up or body piercing jewelry | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Dentures or false teeth, hearing aide, or skin medication patch | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Intra-uterine device (IUD), diaphragm, pessary, or Lap Band | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Any other implanted item | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Kidney disease (including renal transplant or solitary kidney) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes or High blood pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Are you pregnant? (Date of LMP: _____) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Important: Please list all surgical and medical procedures you have had:

Have you ever had?

- | | | |
|--|------------------------------|-----------------------------|
| An injury to your eye involving metal | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| A bullet or shrapnel injury | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| An allergic reaction to any medicine or x-ray contrast (dye) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

I attest that the above information is correct to the best of my knowledge

Signature of person completing form _____ Date: _____

Print Name: _____ Relationship to patient: _____

OFFICE USE ONLY

Questionnaire information reviewed by	Contrast	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Print Name _____	Risk Factors	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Signature _____	eGFR _____	m/mol Date _____	
Date _____	Administered by _____		