Clear Form

BCCH MRI Research Facility
MRI PATIENT SCREENING FORM

SURNAME GIVEN NAME

For Patient safety, this form must be completed accurately. If the form is missing or incomplete, the MRI can be CANCELLED.

WARNING! MRI CANNOT BE PERFORMED IF PATIENT HAS ANY OF THE FOLLOWING:

✘ Cardiac pacemaker ✘ Aneurysm clip ✘ Cochlear implant ✘ Metallic foreign body in eye

DO YOU HAVE:	INITIAL SCREENING		SECOND SCREENING	
Cardiac pacemaker, wires, defibrillator (in-place or removed)	☐ Yes	☐ No	☐ Yes	☐ No
Aneurysm clip	☐ Yes	☐ No	☐ Yes	☐ No
VP Shunt	☐ Yes	☐ No	☐ Yes	☐ No
Neurostimulator or biostimulator	☐ Yes	☐ No	☐ Yes	☐ No
Cochlear implant or other hearing devices	☐ Yes	☐ No	☐ Yes	☐ No
Metallic or foreign object in your body (e.g. bullet, shrapnel)	☐ Yes	☐ No	☐ Yes	☐ No
Have you worked with metal? (e.g. welding, grinding)	☐ Yes	☐ No	☐ Yes	☐ No
Previous injuries to eyes from pieces of metal?	☐ Yes	☐ No	☐ Yes	☐ No
Vascular coil / stent	☐ Yes	☐ No	☐ Yes	☐ No
Implanted drug infusion pump or glucose monitor	☐ Yes	☐ No	☐ Yes	☐ No
Artificial heart valve	☐ Yes	☐ No	☐ Yes	☐ No
Prosthesis (e.g. eye, limb etc.)	☐ Yes	☐ No	☐ Yes	☐ No
Braces, retainers, dentures, implants, palate spreader	☐ Yes	☐ No	☐ Yes	☐ No
Medication Patch	☐ Yes	☐ No	☐ Yes	☐ No
Silver lined/Antimicrobial undergarments (must be removed)	☐ Yes	☐ No	☐ Yes	☐ No
Tattoos or permanent makeup (Temporary, ink, UV activated)	☐ Yes	☐ No	☐ Yes	☐ No
Hair accessories (e.g. wig, extension, pins) or magnetic eyelashes	☐ Yes	☐ No	☐ Yes	☐ No
Could you be pregnant? LMP: _____	☐ Yes	☐ No	☐ Yes	☐ No
Diaphragm/ I.U.D/ pessary	☐ Yes	☐ No	☐ Yes	☐ No
Are you claustrophobic? Rate *Mild 1 2 3 4 5 6 7 8 9 10 Severe*	☐ Yes	☐ No 1	☐ Yes	☐ No

HAVE YOU HAD SURGERY INVOLVING:				
Head / Eye / Neck/Dental	☐ Yes	☐ No	☐ Yes	☐ No
Spine	☐ Yes	☐ No	☐ Yes	☐ No
Chest	☐ Yes	☐ No	☐ Yes	☐ No
Abdomen/Pelvis	☐ Yes	☐ No	☐ Yes	☐ No
Limbs	☐ Yes	☐ No	☐ Yes	☐ No

If answered **Yes** to any of the above, please provide *details* here:

Initial Signature _____ Second Signature _____

Date _____ Date _____

☐ Patient ☐ Parent ☐ RN/MD ☐ MRI Technologist

☐ Research Personnel ☐ Level 2 MRI Personnel

MRI PATIENT PREPARATION (FOR DEPARTMENT USE ONLY)

MEDICAL CONDITIONS:

CURRENT MEDICATIONS

_____

_____

DRUG ALLERGIES

_____

_____

DO YOU HAVE PAIN? ☐ Yes ☐ No

Where? _____

INVOLUNTARY MOVEMENTS? ☐ Yes ☐ No
Seizures? ☐ Yes ☐ No
Description?

_____

_____

_____

_____

OTHER COMMENTS:

Patient changed	☐ Yes	☐ No	☐ N/A
Remove prostheses	☐ Yes	☐ No	☐ N/A
Clean hair/remove hair clips	☐ Yes	☐ No	☐ N/A
Remove makeup	☐ Yes	☐ No	☐ N/A
Remove jewellery/ body piercing	☐ Yes	☐ No	☐ N/A
Remove medical devices (e.g. hearing aids, glucose monitor)	☐ Yes	☐ No	☐ N/A

WEIGHT_____kg / lb HEIGHT_____cm / ft

Contrast

Kidney failure? ☐ Yes ☐ No

GFR within 3 months _____

Any chance of pregnancy? ☐ Yes ☐ No

Breastfeeding? ☐ Yes ☐ No

Implanted vascular access (e.g. PICC, Port-a-cath) ☐ Yes ☐ No

IV setup by: _____ Size: _____G

Site: _____

# of attempts: _____

Contrast: _____

Amount: _____mL

Injection date and time: _____

Injected by: _____

Reaction to contrast ☐ Yes ☐ No
Details:

"Time Out" MRI Safety Check	
	Correct Patient/Parent
	Staff Check – No Metal
	Patient/Parent Check – No Metal
	Equipment Check – MRI Safe Equipment