Queensland Government

Royal Brisbane & Women's Hospital

MAGNETIC RESONANCE IMAGING (MRI) QUESTIONNAIRE

(Complete if applicable)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

MRI uses very strong magnetic fields that are always on and some objects pose a serious threat to your safety, or compromise the examination.

Therefore, this questionnaire is obiligatory and **all** questions must be answered.

If you have any questions please contact MRI Unit.

Height (cm): .....

Weight (kg): .....

Do you have, or have you ever had, any of the following? *(Please tick Yes or No)*

Cardiac Pacemaker/Defibrillator/Pacing Wires/Loop Recorder	☐ Yes ☐ No
Any operations on your heart	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No
Cardiac Stents	☐ Yes ☐ No
Any operations on your brain	☐ Yes ☐ No
Aneurysm clip/coils/shunts	☐ Yes ☐ No
Any implanted electronic device	☐ Yes ☐ No
Ear implant (e.g. Stapes or Cochlear implants)	☐ Yes ☐ No
Neurostimulator (e.g. Spinal or Deep Brain stimulator)	☐ Yes ☐ No
Implanted drug infusion pump	☐ Yes ☐ No
Shunt (Programmable, VP or Spinal shunt)	☐ Yes ☐ No
Any vascular implants (e.g. Stent, Coils, Filter, Graft)	☐ Yes ☐ No
Any other implanted prosthesis or foreign object	☐ Yes ☐ No
Joint replacement or artificial limb/s	☐ Yes ☐ No
Rods, plates, screws in your bones	☐ Yes ☐ No
Bullets or shrapnel injury	☐ Yes ☐ No
Tissue expander	☐ Yes ☐ No
Have you **ever** had metal fragments in your eye?	☐ Yes ☐ No

Have you had any surgery? Please list

Do you have, or have you ever had, any of the following?
(Please give details where appropriate)

Hearing Aid/Eye Implant:	☐ Yes ☐ No
Dentures or removable dental work:	☐ Yes ☐ No
Medication patches on skin:	☐ Yes ☐ No
Body piercing or tattoos:	☐ Yes ☐ No
Claustrophobia:	☐ Yes ☐ No
Require GP medication for MRI:	☐ Yes ☐ No

Are any of the following applicable to you?

Do you have a history of kidney disease?	☐ Yes ☐ No
Do you have diabetes?	☐ Yes ☐ No
Do you have any allergies?	☐ Yes ☐ No
Have you ever had a reaction to contrast?	☐ Yes ☐ No
For Female Patients	
Are you, or could you be pregnant?	☐ Yes ☐ No
Are you breastfeeding?	☐ Yes ☐ No

I confirm that I have read and understood these questions, and have answered them correctly.

Name: ..... Signature ..... Date: ..... / ..... / .....

Completed by:

☐ Patient ☐ Relative/Carer ☐ Doctor - Provide name and contact details below:

.....

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Warning:

Please be aware that prior to entering the scan room **all** metallic objects must be removed including watches, jewellery, hearing aids, wallets, data cards, phones, hair pins and clips, piercings, clothing with metal such as bra or jeans etc. It may also be necessary to remove other items such as makeup.

Please note:

You will be required to change into a hospital gown. Lockers are provided for your convenience.

Office use only:

1st Review by:..... 2nd Review by:.....

Action required:.....

Implant details:

.....

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Outcome:.....

.....

DMI – Contrast

Oral contrast/amount:.....

Skin prep: ☐ 2% Chlorhexidine ☐ Alcohol only

IV inserted: ☐ Insitu ☐ Yes No of attempts:.....

IV access comment:.....

IV cannula gauge:..... Site:.....

Inserted by:.....

Normal saline flush: ☐ 10mls ☐ 50mls Pressure Inj

Contrast Injection: ☐ IV Bolus ☐ Pressure Injector

IV contrast type, volume:.....

Batch:.....

Administered by:.....

IV removed: ☐ Yes ☐ No

Office use only:

eGFR:..... ml/min

Date tested:...../...../.....

Gynae/Breast Patient only

Date of LNMP:...../...../.....

DO NOT WRITE IN THIS BINDING MARGIN