Shared health Soins communs Manitoba

MRI PATIENT SAFETY FORM

IMPORTANT – Please read before filling out form

Certain implants, devices or objects may be hazardous to your health in the MRI environment. If you have any questions or concerns regarding an implant, device or object, please consult with the MR nurse or MR technologist before entering the MR scanner room. This form must be completed by the patient or a relative with a thorough understanding of the patient's medical history.

NAME: **HRN:**

DOB: **PHIN:**

Have you had prior surgery to your eyes, ears, heart, abdomen or brain? ☒ Yes ☒ No

If **YES**, please indicate date and type of surgery. _____

Check Yes or No for each of the following:

Previous MRI exam. Date: _____ Location: _____	☒ Yes	☒ No	Gastroscopy &/or Colonoscopy procedure with metal clips. If yes, Facility: _____ Date: _____	☒ Yes	☒ No
Cardiac pacemaker or implantable cardioverter defibrillator (ICD), loop recorder, or any retained / abandoned or pacer wires	☒ Yes	☒ No			
Heart valve prosthesis	☒ Yes	☒ No	Tattoo or permanent makeup	☒ Yes	☒ No
Brain aneurysm clips or coilings	☒ Yes	☒ No	Implanted contraceptive device	☒ Yes	☒ No
Neurostimulator	☒ Yes	☒ No	Any jewelry that cannot be removed	☒ Yes	☒ No
Shunt (STRATA valve, spinal, VP or intraventricular)	☒ Yes	☒ No	Dentures or partial plates held in with magnets	☒ Yes	☒ No
Electronic implants, stimulators or electrodes	☒ Yes	☒ No	Wig, hairpiece or hair extensions (with clips/magnets	☒ Yes	☒ No
Stent, filter or vascular coil	☒ Yes	☒ No	Hearing aid	☒ Yes	☒ No
Any implants or devices (eye, penile, tissue expander, orthopedic, breast, etc.) _____	☒ Yes	☒ No	Medication patch (nicotine, nitroglycerin, etc…)	☒ Yes	☒ No
Implanted drug infusion pump or glucose monitoring system	☒ Yes	☒ No	Antimicrobial/antibacterial clothing (silver, metallic fibers or nanosilver technology)	☒ Yes	☒ No
Ear implant or cochlear device	☒ Yes	☒ No	Kidney disease, kidney failure or dialysis	☒ Yes	☒ No
Joint replacement or metal plate, screws, nail, artificial limb	☒ Yes	☒ No	Claustrophobia	☒ Yes	☒ No
Any BB, bullet, shrapnel or buckshot ever in body	☒ Yes	☒ No	Pregnant or possibility of pregnancy	☒ Yes	☒ No
Any previous eye injury involving metal from grinding or welding	☒ Yes	☒ No	Physical mobility limitations. If yes, please describe: _____	☒ Yes	☒ No

Patient Height: _____ ft/in _____ m Patient Weight: _____lbs _____ kgs

Information obtained by: ☒ patient ☒ relative_____ _____☒ other: EPR/eChart

Print Name Date

Person Completing Form: ☒ Nurse ☒ Physician _____ _____

Print Name Date

Office Use Only

Creatinine _____ eGFR _____ Date _____ Nurse/Tech Notes:

Contrast _____ Amount _____

Sedation: IV/Oral _____ Time _____

IV site _____ Please circle: 1.5T 3T

Prescreened by: _____ Screened by:_____

Nurse's Name Technologist Name Technologist Signature