Adelaide MRI
Excellence in Imaging

DIAGNOSTIC IMAGING
& INTERVENTIONAL RADIOLOGY

M.R.I. SAFETY QUESTIONAIRE

Name: ....

Date of Birth: ..../......../..........

Approximate Weight: .... **kgs** Today's Date: ..../......../..........

Have you had a previous MRI? ❑ Yes ❑ No

Some of the following may be hazardous to your safety or may interfere with your MRI examination. Please tick the correct box next to every query below.

Any "Yes" answers or questions should be brought to the attention of the MRI Staff.

Do you have any of the following?

Cardiac Pacemaker/Defibrillator and/or Wires	❑ Yes	❑ No
Artificial Heart Valve	❑ Yes	❑ No
Aneurysm Clip(s), Plates or Shunts in your Head	❑ Yes	❑ No
Neurostimulator or Bone Growth Stimulator	❑ Yes	❑ No
Implanted Insulin or Infusion Pump	❑ Yes	❑ No
Cochlear, Otologic or Ear Implant	❑ Yes	❑ No
Artificial Joint or Prosthesis (eye, penile etc.)	❑ Yes	❑ No
Electrodes (on body, in brain)	❑ Yes	❑ No
Intravascular Stents, Coils or Filters	❑ Yes	❑ No
Shunts (spinal or intraventricular)	❑ Yes	❑ No
Vascular Access Ports or Catheters	❑ Yes	❑ No
Tattoos [incl permanent makeup etc.] or Body Piercing(s)	❑ Yes	❑ No
Metal Fragments, Splinters, Bullets or Shrapnel	❑ Yes	❑ No
Metal or Wire Mesh Implants	❑ Yes	❑ No
Wire Sutures or Surgical Staples	❑ Yes	❑ No
Joint Replacement (knee, hip etc.)	❑ Yes	❑ No
Orthopaedic Pins, Rods, Screws, Nails, Plates	❑ Yes	❑ No
Implanted Intra-Uterine Contraceptive Device (IUCD)	❑ Yes	❑ No
Hearing Aid or Dentures	❑ Yes	❑ No
Allergies	❑ Yes	❑ No

Other: *Please Specify* ______________________________

Have you ever had:

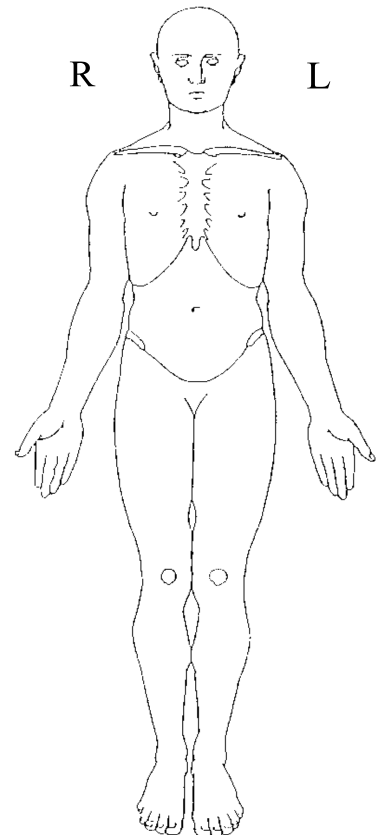
Brain, Head, Eye, Ear surgery?	❑ Yes	❑ No
Artery and/or Vein surgery?	❑ Yes	❑ No
Bone or Heart Surgery?	❑ Yes	❑ No
An Eye injury involving metal?	❑ Yes	❑ No
A job working with metal or as a welder?	❑ Yes	❑ No
An operation in the last six weeks?	❑ Yes	❑ No

Are you:

Pregnant, Possibly Pregnant or Breastfeeding?	❑ Yes	❑ No
Claustrophobic?	❑ Yes	❑ No

Checked by: __________________ *(MRI Staff)*

Please mark on the figure below, the location of any implants or metal on, or inside your body.



This *Safety Questionnaire* was completed by:

Name

Signature

Patient / Staff / Relative