MRI QUESTIONNAIRE

To be completed by the patient before the MRI scan, for your own safety!

Magnetic resonance imaging (MRI) is a medical imaging technique that uses a strong magnetic field and powerful radio waves. It can be dangerous in some cases. To eliminate all risks, please complete and sign the list below.

The scan cannot take place without a completed and signed form.

Patient name: _____ Weight: _____ kg

Date of birth: _____ Height: _____ cm

Available **during the day** by phone on: _____

Questions, part 1: (tick the applicable box)	**Yes**	**No**
Are your veins hard to find?	☐	☐
If yes, does this often require additional assistance from an anaesthetist?	☐	☐
If yes, please contact the MRI department by phone.		
Do you have claustrophobia?	☐	☐
If yes, please contact the MRI department by phone.		
Are you pregnant, or do you think you might be?	☐	☐
If yes, please contact the MRI department by phone.		
Are you breastfeeding?	☐	☐
Do you have metal shavings in your eye, or have you ever had them in the past?	☐	☐
If yes: Did an ophthalmologist remove the shavings?	☐	☐
If no, please contact the MRI department by phone.		
Have you ever been injured by ammunition (shrapnel or bullets)?	☐	☐
If yes, please contact the MRI department by phone.		
Do you have a plate brace?	☐	☐
If yes, please contact the MRI department by phone.		
Do you have a copper IUD?	☐	☐
If yes, please contact the MRI department by phone.		
Do you have an insulin pump?	☐	☐
If yes, it should be disconnected during the MRI scan.		
Do you have a continuous glucose monitor on your skin?	☐	☐
If yes, it must be removed for the MRI scan.		
Do you have a mobile disability that requires the use of assistive devices (e.g., patient lift)?	☐	☐
If yes, please contact the MRI department by phone.		
Have you ever had surgery?	☐	☐
If yes: complete the questions on the next page and sign the form.		
If no: you may skip the following questions and only need to sign this form on the next page.		

See next page

Questions, part 2: (tick the applicable box)	**Yes**	**No**
Do you have a pacemaker or implantable cardioverter-defibrillator (ICD), or have you had one in the past?	☐	☐
Do you have an implantable cardiac monitor? (Reveal or SJM Confirm) *If yes: Please note the type/model number of your heart monitor (if known):* *……...*	☐	☐
Do you have a neurostimulator for pain management, bladder control or otherwise? *If yes: Please note the type/model number of your neurostimulator (if known):* *……..*	☐	☐
Do you have any other implanted electrical device (e.g., BAHA, baclofen pump)? *If yes: Please note the type/model number of the device (if known):* *……*	☐	☐
Do you have vascular clips in your brain (aneurysm clips)? *If yes: In what year did the operation take place?..... In which hospital?.....*	☐	☐
Have you had stents implanted? *If yes: In which blood vessel(s) .....*	☐	☐
Have you ever had inner ear surgery?	☐	☐
If yes: Was anything implanted? *If yes: Please note the type/model number of the implant (if known):* *……*	☐	☐
Do you have a cochlear implant? *If yes: Please note the type/model number of the implant (if known):* *……....*	☐	☐
Do you have any metal bone screws, pins or plates in the area to be examined?	☐	☐
Do you have a tissue expander (in preparation for breast reconstruction)?	☐	☐
Do you have a portacath/powerport?	☐	☐

If you answered yes to one or more of the above questions (Questions, part 2), please contact the MRI department by phone.

I certify that all of the above information is correct. I have read and understood the full text of this form. I have had the opportunity to ask questions about this form.

Patient signature: Date of completion: