

**PATIENT'S INFORMATION**  
(Please Stick Label)

**IMAGING CENTRE**  
**CHECKLIST FOR MAGNETIC RESONANCE IMAGING (MRI) SERVICES**

Berat/ Weight (kg)		Tinggi / Height (cm)		MRI Number	
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Please circle

Patient's ID & Consent	Yes	No	N/A	12 Lead ECG	Yes	No	N/A
No caffeine 24 hours before	Yes	No	N/A	Creatinine level			N/A
No hypertensive drugs 24 hours before	Yes	No	N/A	GFR			N/A
IV line (Pink 20G/ Green 18G)	Yes	No	N/A	Financial Clearance	Yes	No	

Seperti yang dinyatakan di dalam helaian maklumat pesakit, kami memerlukan maklumat berikut: As in the patient information leaflet, we would require the following information:				By patient		By MRI staff	
				Yes	No	Yes	No
Untuk pesakit wanita sahaja / for female patient only Adakah kemungkinan anda sedang mengandung? Tarikh LMP : ____/____/____ Is there any possibility you could be pregnant? Date of LMP : ____/____/____							
Untuk pesakit wanita sahaja / for female patient only. Adakah Anda menyusukan anak? Are you breastfeeding?							
Adakah anda pernah mengalami sawan, asma atau alergi? (jika ya, sila tandakan) _____ Do you suffer from epilepsy, asthma or allergies (if yes, please specified)? _____ I/V Hydrocort 200mg stat given: _____ (Jika ya pada salah satu atau semua / if yes either one or all)							
Adakah anda tahu masalah berkaitan buah pinggang anda atau adakah anda sedang dalam rawatan dialisis? Are you aware of any problem with your kidneys or are you on dialysis?							
Adakah anda menanti untuk pemindahan hati (liver transplant)? Are you awaiting a liver transplant?							
Bolehkah anda berbaring sekurang-kurangnya 1 jam dan menahan nafas selama 10 - 15 saat? jika tidak, sila jelaskan kenapa? Are you able to lie flat for at least 1 hour and breathe hold for 10 - 15 seconds? If not, please state why?							

Adakah anda mempunyai implan? / Do you have implant?

		By patient		By MRI staff				By patient		By MRI staff	
		Yes	No	Yes	No			Yes	No	Yes	No
1. PPM						5. Implan mata / Eye implant					
2. TPM						6. Implan tulang belakang / Spine implant					
3. ICD						7. Other : i)					
4. Implan telinga / Ear implant						ii)					

Sudahkah anda menanggalkan / Have you removed:

		By patient		By MRI staff				By patient		By MRI staff	
		Yes	No	Yes	No			Yes	No	Yes	No
1. Jam / Watch						7. Kunci / Keys					
2. Kad bank / Bankcards						8. Syiling / Coins					
3. Telefon bimbit / Hand phone						9. Barang kemas / Jewellery					
4. Gigi palsu / Dentures						10. Klip rambut / Hair Clip					
5. Cermin mata / Spectacles						11. Other :i)					
6. Alat bantu pendengaran						ii)					

	Yes	No		Yes	No
After procedure is completed, any sign of high risk for fall?			If Yes, intervention done?		

Diperiksa oleh: 1. ....  
Checked By (Cardiac Angiographer / Staff Nurse)

2. ....  
(Cardiac Angiographer / Staff Nurse)

Tarikh/ Date: ..... Masa/Time:.....

Tarikh/ Date: ..... Masa/Time:.....

Dengan tandatangan di bawah, saya mengakui yang saya telah membaca dan memahami maklumat prosedur yang telah diberikan dan penerangan telah diberikan oleh orang yang berkelayakan serta saya telah menjawab soalan di atas dengan betul.

By signing below, I acknowledge that I have read the Patient Information Leaflet, which a qualified person has explained procedure to me, and I have answered the above questions correctly.

Tandatangan pesakit/ Patient's Signature: .....

Tarikh/ Date: ..... Masa/Time:.....

Revision 02. Effective Date: 13 May 2019