PD3967

MRI Patient Screening Form

Telephone number: 01142 268000
Monday to Friday: 0800 - 1730, Saturday: 0800 - 1600

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

It is VITAL that this form is completed before you come for your appointment. Please telephone the MRI department (see above) if you answer YES to any of the questions. Failure to do so may result in your scan being rescheduled or cancelled.

Name:	**Date of birth**	Height	Weight
Address: (1st line or post code or telephone number)			

Approximate date of last MRI scan:	At which Hospital?:	
Have you EVER had a pacemaker, implantable cardiac defibrillator, loop recorder or other cardiac device? - Please give details (make/model) in the box below	Yes	No
Have you EVER had surgery to your head, heart, spine, eyes or ears? - Please give details in the box below	Yes	No
Have you EVER had any surgical clips, aneurysm clips, stents or shunts? - Please give details in the box below	Yes	No
Have you EVER had any implanted medical devices? - *For example, drug infusion device, neurostimulator, BAHA/cochlear implant, contraceptive coil, ported breast implants, heart valve, gastric band, prosthesis: limb, eye, ear, nose - nasal septal button* - Please give details (make/model) in the box below	Yes	No
Have you EVER had any metal or metal fragments enter your eyes? - If yes, was it removed in Hospital?	Yes	No
Have you EVER had any metal or metal fragments (shrapnel, bullets, needles, swarf etc) penetrate any part of your body? - Please give details in the box below	Yes	No
Have you EVER had a Pill Cam, Capsule Endoscopy or BravoPH procedure ?	Yes	No
Do you have chronic kidney disease, kidney failure, kidney transplants or kidney dialysis? - if yes, please give details in the box below. (For example, what days do you dialyse on?)	Yes	No
Is there any possibility that you may be pregnant?	Yes	No
Are you currently breastfeeding/chestfeeding?	Yes	No
Further details:	**QR Code to Patient info**	

BEFORE YOUR SCAN YOU WILL NEED TO REMOVE ALL METALLIC OBJECTS FROM YOURSELF

For example: prosthetic limbs, phones, watches, coins, keys, credit cards, jewellery, belts, hairgrips, wigs, hair weaves, hair extensions, dentures, hearing aids and glasses etc. Please try not to bring valuables with you - STH cannot be held liable for any loss. Clothes with metallic parts (clips/hooks/studs) or with any silver impregnated antimicrobial materials must be removed - hospital gowns are available to change into and lockers or baskets will be provided to store your belongings.

Your appointment WILL be rescheduled if you bring unaccompanied children with you

- At your appointment, please tell the staff if you have, or are wearing, any permanent cosmetics, microblading, tattoos, magnetic eyelashes, coloured contact lenses, dermal piercings or non-removable jewellery

- At your appointment, please tell the staff if you have epilepsy, diabetes, allergies or poorly controlled asthma

- Skin or transdermal patches containing metal (silver backed etc) or containing Fentanyl/Buprenorphine **must** be removed prior to your scan. All other skin/transdermal patches should be removed prior to your scan to avoid the risk of over delivery of the active ingredient.
- please check with staff **before** removing insulin pumps and/or glucose monitors (Libre, Dexcom etc). These may still need to be removed.
Be aware that you may need to renew/replace these items after your scan - bring replacements to your appointment.

Your data is used according to the STH Patient Privacy Notice. This may include use of anonymised data for research and teaching purposes. Please see https://www.sth.nhs.uk/about-us/information-governance/gdpr/ for further information including details of the National Data Opt Out program.

Please sign below and bring this form to your appointment with you.
I have read and understood the questions above and have answered them to the best of my knowledge

Signature:	Date:
MRI Radiographer:	Date:

MRI Cannulation Checklist - For Office Use Only

Patient's name:	**Date of Birth:** / /

Positive patient ID?			Yes	No
Anaphylaxis Drugs available & in date?			Yes	No
For Primovist contrast only				
eGFr results >30	Yes	No	Date of eGFr result:	
If eGFr <30, which radiologist/nephrologist has agreed to the scan:				

For Buscopan/Mebeverine only - *Does the patient have…*			
Buscopan	Does the patient have any heart problems?	Yes	No
Buscopan	Does the patient have Glaucoma (raised intraorbital pressure)?	Yes	No
Buscopan	Does the patient have an enlarged prostate with urinary retention?	Yes	No
Buscopan	Does the patient have Myasthenia Gravis (a rare muscle weakness problem)?	Yes	No
Buscopan	Does the patient have any gut blockage issues, inactive gut or Megacolon?	Yes	No
Mebeverine	Does the patient have constipation caused by a condition called paralytic ileus (an inactive gut)	Yes	No
Mebeverine	Is the patient unable to digest galactose (a sugar found in lactose)? - a rare inherited condition	Yes	No
Buscopan / Mebeverine	Is the patient allergic to Buscopan/Mebeverine? (circle as required)	Yes	No
Buscopan / Mebeverine	Has the patient had antispasmodics today? **If yes, do not administer Buscopan or Mebeverine**	Yes	No
Buscopan / Mebeverine	Is the patient pregnant or breastfeeding/chestfeeding?	Yes	No

Patients Signature	**Radiographers Signature**	Batch No	Batch Date

Cannulation record	**Success**	**Fail**	**Cannula size**				**Cannula site**
Number of attempts:			Yellow 24G	Blue 22G	Pink 20G	Green 18G	

Cannulated on ward?		Person cannulating (Signature & Print name)
Yes	No	

Inpatients returning to ward with cannula:	Dated?		Capped?		Checked by (signature):
	Yes	No	Yes	No	

Record of Oral or IV contrast, fluids or pharmacological agents administered (circle as appropriate)			
Gadoxetate Di-Sodium (Primovist) / Gadovist / Dotarem / Regadenoson / Mannitol / Saline / Other:			
Brand/Batch number/Product label	Dose	Time	Given/Injected by (Signature & print name)
Saline Bolus/Batch number	Dose	Time	Given/Injected by (Signature & print name)

In case of extravasation, give details:	DATIX number