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MRI Safety Screening Form

(Place Patient Label Here)

Every patient MUST complete this form prior to MRI scan.
For inpatient request, fax completed form to MRI department.

PATIENT INFORMATION

LAST NAME: FIRST NAME:

For staff or contractor, indicate your company & profession:

DATE OF BIRTH			HEIGHT ☐ cm ☐ ft' in"	WEIGHT ☐ kg ☐ lbs
YYYY	MM	DD		

Your safety is very important to us. Please complete the following to help us keep you safe.
If you need help filling out the form, please let a staff member know.

The MRI scanner is a very strong magnet. It might be unsafe if you have had surgeries with certain metal or electronic implants.

For the MRI scan, you must remove all body piercings, hair accessories, jewelry, hearing aids, credit cards, coins, and other metallic or electronic personal items (watches, phones, etc.). Please tell us if you cannot remove any of these items.

To keep you as safe as possible, you must wear a hospital gown. You must remove undergarments that are not 100% cotton or cotton/polyester blend. Athletic undergarments can have metallic fibres and could cause a skin burn.

We provide you with a locker to secure your belongings.

List all previous surgeries and approximate dates (if you require more space, please let a staff member know):

☐ No surgery of any kind

List any medical procedures in the last 6 weeks (include injections, biopsies, colonoscopies, acupuncture):

☐ No medical procedures in last 6 weeks

List all allergies:

☐ No known allergies

Tell us about any implanted medical devices or other possible hazards that could affect the MRI Scan:

	IMPLANTED MEDICAL DEVICES	YES	NO		OTHER POSSIBLE HAZARDS	YES	NO
1	Stents, filters or coils			1	Injury to your eye from a metal object		
2	Heart valve			2	Injury by metallic object (bullet, shrapnel, etc.)		
3	Brain aneurysm clip			3	Hearing aid(s)		
4	IV access (Broviac, Port-a-Cath, Hickman, PICC, etc.)			4	Dentures. Dental retainers, braces or implants		
5	Pacemaker, defibrillator or leads (in-place or removed)			5	Hair accessories (wig, extensions, pins, barrettes, clips)		
6	Neurostimulator or biostimulator (in-place or removed)			6	Body piercings		
7	VP shunt			7	Tattoos or permanent makeup		
8	IUD, diaphragm or pessary			8	Magnetic eyelashes		
9	Metal rods, pins, screws or joint replacements			9	Medication patch		
10	Prosthesis (eye, limb, penile, etc.)			10	Glucose monitoring sensor		
11	Cochlear (middle ear) implant			11	On dialysis		
12	Eye implant, eyelid spring or wire			12	Breastfeeding		
13	Electronic device or implant (pill cam, infusion pump, etc.)			13	Known or possible pregnancy		
14	Breast tissue expander			14	Claustrophobia: ☐ No ☐ Mild ☐ Moderate ☐ Severe		

If **Yes** to any of the above, please provide a short description of each:

By signing, I confirm that I have read this form completely and that the information I have provided is accurate to the best of my knowledge.

SIGNATURE:	IF FORM NOT COMPLETED BY PATIENT, INDICATE RELATIONSHIP:	DATE YYYY MM DD

FOR STAFF USE: Time Out Checklist ☐ Patient Name ☐ Date of Birth ☐ Procedure & Side ☐ MRI Safety Checked

LEVEL 2 MR-PERSONNEL WHO PERFORMED SCREENING:	DATE YYYY MM DD

MRI Technologist Work Sheet
(For Staff Use Only)

Patient Name:
(first & last)

Patient Date of Birth:
(yyyy/mm/dd)

(Affix Demographic Label Here)

Vascular Access Device (VAD):

Status: ☐ New PIV ☐ PIV In-Situ ☐ Central Line In-Situ
Site: ☐ Right ☐ Left Location: _____
Size: ☐ 18G ☐ 20G ☐ 22G ☐ 24G
Attempts: _____
Accessed By: _____

Contrast Agent:

Route: ☐ VAD ☐ Oral ☐ Rectal ☐ Vaginal
Solution: ☐ Gadovist ☐ Primovist ☐ Multihance ☐ ProHance
☐ Peglyte ☐ Breeza ☐ Sterile Gel Other: _____
Power Injector: ☐ No ☐ Yes Rate: _____
Dose: _____
Time: _____
Administered By: _____

Medication:

Solution: ☐ Buscopan ☐ Glucagon ☐ Lasix
☐ Adenosine Other: _____
Dose: _____
Time: _____
Administered By: _____

Post Exam VAD Care:

Status: ☐ Removed ☐ Maintained *(saline flushed)* ☐ Maintained (*heparin flushed)*
Complication: ☐ No ☐ Yes *(comment in adverse event section)*
Time: _____

Technologist Notes:

_____
_____
_____
_____

Exam Performed By: _____
Date (yyyy/mm/dd): _____
Supervising Radiologist: _____

Actions taken for adverse event or reaction:

_____
_____
_____
_____

if applicable, lot # and expiry: _____

PSLS Created: ☐ Yes ☐ No
EMR Updated: ☐ Yes ☐ No