



MEDICAL IMAGING DEPARTMENT

Medical Imaging Department – Magnetic Resonance Imaging (MRI)
Level 0, Barker Street, Randwick NSW 2031

Telephone: (02) 9382 0300 Fax: (02) 9382 2340

MAGNETIC RESONANCE (MR) SCREENING FORM FOR INDIVIDUALS*

The MRI environment may be hazardous to individuals entering the immediate vicinity of the magnet if they have certain metallic, electronic, magnetic or mechanical implants, devices or objects. All individuals entering the magnet room are required to complete the form BEFORE entering the magnet room. Be advised that the MR magnet is ALWAYS on even when not scanning.

Date: ____ / ____ / ____

Name: _____ Age: _____

Address: _____

City: _____ State: _____ Postcode: _____ Telephone: _____

1. Have you ever had any previous surgery? Yes No

If yes, please indicate date and type of surgery:

Date: ____ / ____ / ____ Type: _____

2. Have you had an injury to the eye involving any metal? Yes No

If yes, please detail: _____

3. Have you ever been injured by a metallic object (e.g. bullet, shrapnel, etc.) Yes No

If yes, please detail: _____

4. Are you pregnant or suspect that you are pregnant? Yes No

5. Have you ever done any metal work, welding or grinding? Yes No

WARNING: Certain implants and devices can prove dangerous to you in the MR environment. DO NOT enter the magnet room if you have any concerns regarding implants, devices, or any object on your person.

Please indicate if you have any of the following:

Brain Aneurysm clip	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cardiac Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>
Electronic implant or device	Yes <input type="checkbox"/> No <input type="checkbox"/>
Magnetically activated implant or device	Yes <input type="checkbox"/> No <input type="checkbox"/>
Neurostimulator	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cochlear Implant	Yes <input type="checkbox"/> No <input type="checkbox"/>
Insulin or Infusion Pump	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any type of prosthesis or implant	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any metallic fragment or foreign body	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hearing aid	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other implant _____	Yes <input type="checkbox"/> No <input type="checkbox"/>

I confirm that to the best of my knowledge, the above information is correct. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature of person completing the form _____ Date: ____ / ____ / ____

Form information reviewed by (Print name) _____ Signature _____ MRI Radiographer Nurse

*Note this form is not to be used for patient screening.



THE
PRINCE OF WALES
HOSPITAL AND
MEDICAL IMAGING DEPARTMENT



SYDNEY CHILDREN'S HOSPITAL
RANDWICK

Ground Floor, Barker Street Entrance, Randwick

Phone: 02 93820300 Option 3 for Booking Enquiries

FAX: 02 93820304

Email: SESLHD-MedicalImagingPOW@health.nsw.gov.au

MRN: _____

NAME: _____

DATE: _____

TIME: _____

Please note that you will need to arrive **15 minutes** before your appointment time.

Please make sure to bring your **Medicare card**. If you do not have a Medicare card/or your child is not yet registered with Medicare, please arrive 30 minutes before your appointment as you will need to pay for the procedure. Payments are made at the cashiers and you will need paperwork from our department before you go to the cashier.

If you are running late or can not attend your appointment, please ring the department to notify us, we may need to change your appointment time.

BARIUM SWALLOW or SMALL BOWEL SERIES

PREPARATION:

Please follow the guide:

PAEDIATRICS: 0-3 years Miss last feed
 3 years and over Fast for 6 hours before procedure

ADULTS: Fast for 6 hours before procedure



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Preparation: Please follow the following preparation guide:

ULTRASOUND ABDOMEN

ADULTS AND PAEDIATRICS OVER 12:

Fasting 8 hours prior to procedure. Medication may be taken with water.

PAEDIATRICS UNDER 12:

No milk or solids to be given 4 hours prior.

For any other procedures, please follow instructions from the booking clerk.



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NO PREPARATION FOR THIS TEST

For any other procedures, please follow instructions from the booking clerk.



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Preparation: Please follow the following preparation guide:

ULTRASOUND RENAL ADULTS

Empty bladder at _____

Drink **1 litre of water** over the **next 30 minutes** from _____

Do not empty bladder.

PAEDIATRIC RENAL AND PELVIC ULTRASOUNDS.

PAEDIATRICS OVER 10-14:

Drink 600 mls water. Do not empty bladder 1 hour prior to appointment.

PAEDIATRICS UNDER 10:

300 mls water and if toilet trained, do not empty bladder 1 hour prior to appointment.

BABIES:

Give plenty of fluid prior to appointment.

For any other procedures, please follow instructions from the booking clerk.