affidea

— nothing is more important than health

MRI Safety Questionnaire

Patient Name: ______________________ Date of Birth: DD / MM / YY

Mobile Number: ______________________ Patient's Weight: ______________________

or Phone Number: ______________________ (required for scan acquisition, please specify kilos or stones)

NB: PLEASE INFORM A RADIOGRAPHER IF YOU ANSWER 'YES' TO ANY OF THE FOLLOWING QUESTIONS

Question	YES	NO
Have you ever had surgery on your heart? Type: ______________________	☐	☐
Do you have a Cardiac Pacemaker or artificial heart valve?	☐	☐
Have you had surgery on your brain or head? Type: ______________________	☐	☐
Have you had aneurysm clips inserted to stop a bleed in the brain or elsewhere?	☐	☐
Have you had an eye or ear (cochlear) implant?	☐	☐
Have you ever had metal fragments in your eyes?	☐	☐
Have you any replacement joints or metal implants/plates/clips?	☐	☐
Do you have any dentures/dental plate?	☐	☐
Do you have any shrapnel (metal fragments) from an injury?	☐	☐
Do you have a hearing aid in at the moment?	☐	☐
Do you suffer from epilepsy or have you recently had a seizure?	☐	☐
Do you have a spinal or pain stimulator?	☐	☐
Do you have tattoos or body piercings or a medicated skin patch?	☐	☐
Do you have an artificial limb/caliper/brace?	☐	☐
Neck/back/spine Mri Patients: Have you ever had surgery on your spine?	☐	☐
If yes: Type: ______________________ When? ______________________		
Do you have asthma?	☐	☐
Do you suffer from renal disease?	☐	☐
Do you have diabetes?	☐	☐
Do you have any allergies? If yes: Name: ______________________	☐	☐
Female Patients: Could you be pregnant?	☐	☐

I am aware that Affidea Ireland may request previous images and reports

Patient's Signature: ______________________ Date: ______________________

Radiographer's Signature: ______________________ Comments: ______________________

Do you give your consent should an injection of MRI contrast be required? ☐ ☐

This may be required to enhance the clarity of your images.

Please ask the Radiographer to explain this further to you should an injection be required

While waiting for your scan please remove all loose metal objects from your person including the following: All jewellery, watch, earrings, hairclips, wallets/coins/bank cards, keys, hearing aid, mobile phones and please switch off your mobile phone.

Office Use Only

eGFR ____________ ml/min/1.73m2 Creatinine level ____________ µmol/l Taken by: ______________________

Contrast Given: ______________________ Amount ____________ Administered by: ______________________