

## Safety Questionnaire

NAME: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: Male  Female

*MRI involves taking pictures of the body using a strong magnetic field. For your safety it is important that you read and answer the questions below carefully. Please notify the radiographer if you answer YES to any of the following.*

Do you have or have you ever had:	YES	NO	Radiographer Use Only
Cardiac pacemaker or defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>	
Surgery on your heart (e.g. heart valve replacement)?	<input type="checkbox"/>	<input type="checkbox"/>	
Surgery on your head (e.g. aneurysm clip, shunt)?	<input type="checkbox"/>	<input type="checkbox"/>	
Any surgery in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	
Any surgery relevant to the body area being scanned?	<input type="checkbox"/>	<input type="checkbox"/>	
Eye or ear implant?	<input type="checkbox"/>	<input type="checkbox"/>	
Clips, pins, screws, plates, an artificial limb, surgical corset, joint replacement or implant in any part of your body?	<input type="checkbox"/>	<input type="checkbox"/>	
Coils, filters or shunts?	<input type="checkbox"/>	<input type="checkbox"/>	
Any electronically or mechanically activated implant?	<input type="checkbox"/>	<input type="checkbox"/>	
Medicated skin patch?	<input type="checkbox"/>	<input type="checkbox"/>	
An implanted drug or infusion pump?	<input type="checkbox"/>	<input type="checkbox"/>	
Gunshot or shrapnel injury?	<input type="checkbox"/>	<input type="checkbox"/>	
Body piercings, tattoos, dentures, dental plate or hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	
Fit, blackout or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you <b>ever</b> worked with metal, welding or grinding?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had an eye injury or had metal fragments in your eyes?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any previous imaging?	<input type="checkbox"/>	<input type="checkbox"/>	

Female Patients Only			
Is there any possibility that you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	LMP: _____
Do you have a contraceptive coil?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>	

- I have removed all metal objects from my person including mobile phone, keys, coins, wallet, dentures, glasses, hearing aid, jewellery etc.
- I have read and understood the above questions and I can confirm that I have answered them to the best of my knowledge.

Patient Signature	Date
Staff Signature	Date

**Note:** For patients under 16 a parent or guardian must sign the questionnaire on the patient's behalf.

**Periodically we may audit a proportion of studies performed at this imaging centre for quality purposes. All data will be dealt with confidentially and in conjunction with data protection legislation.**