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| **MR Patient Safety Questionnaire** | | | | | | |
| **PATIENT ADDRESS LABEL** | | **DOC SCAN LABEL** | | | | |
| **IT IS VERY IMPORTANT YOU ANSWER ALL THE FOLLOWING QUESTIONS CAREFULLY.**  **If you answer yes to any question please notify the MRI department:**  **email** [**mri.cah@southerntrust.hscni.net**](mailto:mri.cah@southerntrust.hscni.net) **Tel: 028 375 63795 (outpatient)/028 375 60663 (inpatient)** | | | | | | |
| **Do you have, or have you EVER had:** | | | **Yes** | **No** | **Details** | |
| A pacemaker / implanted cardiac device / pacing wires? | | |  |  |  | |
| An aneurysm clip /a programmable shunt/ neurostimulator? | | |  |  |  | |
| Surgery at **ANY** time to the: | Brain/Eyes/Ears? | |  |  |  | |
| Heart? | |  |  |  | |
| Chest/Abdomen/Spine? | |  |  |  | |
| Any surgery in your lifetime? | | |  |  |  | |
| Any clips, pins, plates, stents, filters, joint replacements, artificial limb, calliper, gastric band, (ring) pessary, penile implant, tissue expander, drug pump, diabetic monitor or **ANY** **IMPLANTS** in **ANY** part of your body? | | |  |  |  | |
| Any endoscopy procedures, including capsule endoscopy (PillCam)? | | |  |  |  | |
| Any implanted stimulators? | | |  |  |  | |
| Any metal fragments or shrapnel in your eyes or skin **AT ANY TIME** from welding or other gunshot or shrapnel injuries? | | |  |  |  | |
| Any body piercings, tattoos, magnetic eyelashes, permanent makeup, hair extensions, medical patches, silver dressings, dentures, dental plate or hearing aids? | | |  |  |  | **Tattoo advice given** |
| Are you connected to a syringe driver? | | |  |  |  | |
| Any monitoring devices or medicine pumps? | | |  |  |  | |
| A fit, a blackout or epilepsy? | | |  |  |  | |
| Any known or suspected infection? | | |  |  |  | |

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| **Pregnancy Status (age 11-55)** | **Yes** | **No** | **Radiographer Use** |
| Is there any possibility that you could be pregnant? |  |  |  |
| Are you breast-feeding? |  |  |  |
| What is the start date of your last period? | **\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_** | | |
| If LMP date is greater than 28 day but the patient is confident there is no possibility of pregnancy they can confirm this and consent to continuing the examination by signing below: | | | |
| Patient signature Date  🗶 | | | |

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| **Do you require any assistance with your mobility?** | | | | |
| No | Assistance of 1 | Assistance of 2 | Hoist | Bed transfer |
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Please turn over…

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| Have you had an MRI scan before? | | **DOC SCAN LABEL** |
| When? |  |
| Which hospital? |  |

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| **Do You have** | **Yes** | **No** | **Radiographer use** |
| Any allergies, hay fever, unstable asthma, diabetes or glaucoma? |  |  |  |
| A reaction to any contrast agent (dye)? |  |  |  |
| Kidney impairment / surgery |  |  |  |
| Heart disease or high blood pressure or diabetes? |  |  |  |
| A liver transplant or are awaiting a liver transplant? |  |  |  |
| Are you over 65 years old? |  |  |  |

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| **Consent** | | | | | | |
| If I need an injection of contrast agent (dye), I consent for this to take place. | | | | | |  |
| I will remove all metal including mobile phones, keys, hair clips, watches, coins, credit cards, body piercings, jewellery, hearing aids, false teeth (with metal clips), etc... before entering the MRI Suite | | | | | |  |
| I confirm that the above information is accurate to the best of my knowledge and I consent to having the MRI scan | | | | | |  |
| Patient Signature | 🗶 | | | **Date** |  | |
| Interpreter Signature | 🗶 | | | **Date** |  | |
| **Below only for completion if patient unable to complete own form**  **\* For patients under 16, a parent or guardian must sign on the patient’s behalf.**  **\*\*For confused patients the next of kin should sign on the patient’s behalf and provide contact number.** | | | | | | |
| Guardian/ Next of Kin Signature | | 🗶 | | **Date** |  | |
| *Print name* | | *relationship to patient* | *Contact telephone number* | | | |

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| **\*\*Below for MRI staff use only\*\*** | | | | | |
| Next of Kin phone call | |  | | **Date** |  |
| Radiographer 1 / Radiography Assistant | |  | | **Date** |  |
| Radiographer 2  *final pause & check* | |  | | **Date** |  |
| Radiologist use (if required)  Comment:  Signature: Date | | | | | |
| Patient weight: | Patient Height: | | eGFR: >60 / 30-60 / <30 (ml/min/1.73m2)  Date: | | |

Please turn over…