

## CLINICAL MRI SAFETY SCREENING FORM

Please complete both sides

**Patient name:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **kg** **Height:** \_\_\_\_\_ **m**

Please carefully check the following. Some items can interfere with MR examinations, and may be hazardous to your safety. Your answers will be kept strictly confidential. **Clearly mark your answer with a circle.**

<b>IF YOU HAVE ANY QUESTIONS THEN PLEASE ASK US BEFORE YOUR SCAN</b>		
Do you have a heart pacemaker or pacing wires?	YES	NO
Have you had any heart surgery?	YES	NO
Have you had any surgery to your head (including eyes/ears/brain), neck or spine?	YES	NO
Do you have any implanted devices (e.g. programmable hydrocephalus shunt, nerve stimulator, cochlea implant, aneurysm clip)?	YES	NO
Have you had any operation involving metallic pins / plates / screws / wires?	YES	NO
Have you ever had any other surgical procedure of any kind or gastroscopy including capsule endoscopy (PillCam ®)	YES	NO
Have you <b>ever</b> sustained any injuries involving metal to the eyes or any other part of the body?	YES	NO
Have you ever had a serious accident (e.g. road traffic accident, explosion injury, shooting, shrapnel injury?)	YES	NO
Have you ever had a fit or blackout, or do you suffer from epilepsy or diabetes?	YES	NO
Do you have any of the following (if yes please circle): <div style="display: flex; justify-content: space-between; font-size: small;"> <div style="width: 30%;">Body/dermal piercing/jewellery</div> <div style="width: 30%;">Hearing aid</div> <div style="width: 30%;">Tattoos</div> </div> <div style="display: flex; justify-content: space-between; font-size: small;"> <div style="width: 30%;">Dentures, dental implants</div> <div style="width: 30%;">Skin patches (nicotine, pain, contraceptive, HRT, nitro)</div> <div style="width: 30%;">Artificial limbs, prosthesis, splints or supports</div> </div>		
FOR WOMEN OF CHILDBEARING AGE:	Do you have an IUD (coil)?	YES NO
	Could you be pregnant?	YES NO
Have you removed your watch, spectacles, hearing aids, keys, coins, jewellery, hair grips?	YES	NO
Are you wearing any clothing that contains metallic threads or is "anti-microbial"?	YES	NO
I agree to gift anonymous images and data collected, to the University of Oxford to be used for education, publication and research, which may include commercial collaboration.	YES	NO
Are you happy to be contacted about potential research?	YES	NO

**NO METAL OBJECTS TO BE TAKEN INTO THE MAGNET ROOM**

Patient /Guardian signature \_\_\_\_\_ Date of study: \_\_\_\_\_

**For admin use**

Screened by \_\_\_\_\_ *Signature:*

*Print name:* \_\_\_\_\_

<b>For scans using contrast agent only:</b> <i>(please ask a member of staff if you don't know whether your scan will involve contrast agent)</i>		
Have you had MR contrast agent before? (please leave blank if unknown)	YES	NO
Are you aware of any problems with your kidneys?	YES	NO
Do you have any allergies to medications? If yes please give details	YES	NO
Are you currently breast-feeding?	YES	NO

<b>Notes (for staff use only) - 1.5T / 3T (please circle magnet used)</b>
<p>Heart rate:</p> <p>Rhythm:</p> <p>Scanned by:</p> <p>The patient has been advised to let staff know if they experience any discomfort or heating during the scan due to the presence of tattoos/non-removable jewellery/piercing/implant</p> <p>Yes / No / NA</p> <p>Signature (Member of staff):</p> <p>Signature (Patient):</p> <p>Date:</p>

<b>Contrast</b>	
Contrast name	
Dose/volume	
Batch number	
Expiry date	
Time of administration	
Given by	
Creatinine-Date	
eGFR	
Adenosine : batch number and expiry date	
Regadenoson: batch number / expiry date	