University of Oxford
Centre for Clinical Magnetic Resonance Research

Oxford University Hospitals NHS
NHS Foundation Trust

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**. **Details of any surgeries/ injuries etc. should be provided overleaf**

IF YOU HAVE ANY QUESTIONS THEN PLEASE ASK US BEFORE YOUR SCAN		
Do you have a pacemaker, pacing wires or an implanted cardiac defibrillator (ICD)?	YES	NO
Have you had any heart surgery?	YES	NO
Have you had any surgery to your head (including eyes/ears/brain)?	YES	NO
Have you had any surgery to your neck or spine?	YES	NO
Do you have any implanted devices (e.g. programmable hydrocephalus shunt, nerve stimulator, cochlea implant or aneurysm clip)?	YES	NO
Have you had any operation involving metallic pins, plates, screws, wires or mesh?	YES	NO
Have you ever had any other surgical procedure of any kind? (Please list overleaf)	YES	NO
Have you ever had a capsule endoscopy (PillCam ®)	YES	NO
Have you **ever** 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, industrial accident, explosion injury, shooting injury or 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): Body/dermal piercing/jewellery — Hearing aid — Tattoos Dentures, dental implants, dental braces, dental bridge — Skin patches (nicotine, pain, contraceptive, HRT, nitro) — Artificial limbs, prosthesis, splints or supports		
FOR WOMEN OF CHILDBEARING AGE: Do you have an IUD (coil)?	YES	NO
FOR WOMEN OF CHILDBEARING AGE: Could you be pregnant?	YES	NO
Are you wearing any clothing that contains silver fibres or is “anti-microbial”?	YES	NO
Have you removed your watch, spectacles, hearing aids, keys, coins, jewellery and hair grips?	YES	NO
I agree to gift anonymous images and data collected, to the University of Oxford and the Oxford University NHS Foundation Trust to be used for education, publication, clinical audit and/ or research, which may include commercial collaboration.	YES	NO
Are you happy to be contacted about participation in 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:*

Use this space to record details of any injury/ surgery or additional information

For scans using contrast agent only: *(please ask a member of staff if you don't know whether your scan will involve contrast agent)*		
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

Notes (for staff use only) - 1.5T / 3T (please circle magnet used)

Heart rate:

Rhythm:

Scanned by:

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

Yes / No / NA

Signature (Member of staff):

Signature (Patient):

Date:

Contrast	
Contrast name	
Dose/volume	
Batch number	
Expiry date	
Time of administration	
Given by	
eGFR	