SOUTH COAST RADIOLOGY | DARLING DOWNS RADIOLOGY | MACKAY RADIOLOGY

PATIENT SAFETY QUESTIONNAIRE AND CONSENT FOR MAGNETIC RESONANCE IMAGING (MRI)

This questionnaire is vital information required by our MRI staff to determine if you can enter the strong magnetic field in the MRI scan room. If you are uncertain about your answers, please discuss these with the MRI staff before your scan.

FULL NAME: _____ **DOB:** _____ **WEIGHT:** _____ kg **HEIGHT:** _____ cm

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Any heart surgery? Yes ☐ No ☐
If yes please give details:
When was your surgery? _____

Any surgery involving metal implants? Yes ☐ No ☐
If yes please give details:
When was your surgery? _____
Do you have evidence (documents) in writing of your implants from your doctor? Yes ☐ No ☐
Have you brought these documents along today? Yes ☐ No ☐

Any brain, ear or eye surgery? Yes ☐ No ☐
If yes please give details:
When was your surgery? _____

Any other surgery in the last 3 months? Yes ☐ No ☐
If yes please give details:
When was your surgery? _____

Injection of Gadolinium Based Contrast Agent (GBCA)

You may be required to have an injection as part of your MRI scan. This can be either requested by your doctor or by our specialist radiologists to aid in the diagnosis of your scans. If required, we would need to inject a Gadolinium Based Contrast Agent (GBCA) into your body. This injection usually has no side affects, however, may cause unwanted effects in some people including allergic reaction on rare occasions. These range from feeling pressure, warmth or cool sensations during injection, to skin reactions, such as hives or anaphylaxis. In a very small percentage of cases, people with poor kidney function may be at risk of contracting Nephrogenic Systemic Fibrosis (NSF), which may affect internal organs. In cases of poor kidney function GBCA would not be administered.

DO YOU HAVE ANY OF THE FOLLOWING? (please circle answers)

Claustrophobia?	Yes	No	Back Surgery?	Yes	No
Cardiac Pacemaker?	Yes	No	Kidney Disease or Renal Impairment?	Yes	No
Aneurysm Clips?	Yes	No	Tattoos or permanent eye/lip liner?	Yes	No
Neurostimulator?	Yes	No	Liver Transplant?	Yes	No
Ear Implant?	Yes	No	Bone Growth Stimulator?	Yes	No
Stents, coils or IVC filters?	Yes	No	Bullets, pellets or shrapnel?	Yes	No
Brain Shunt?	Yes	No	Hearing Aid?	Yes	No
Implanted infusion pump?	Yes	No	Body piercing/permanent jewellery/metal in clothing?	Yes	No
Metal in your eyes (at any stage)?	Yes	No	Artificial Joints or Limbs?	Yes	No
Epicardial Wires?	Yes	No	Dentures or Braces?	Yes	No
Heart Valve?	Yes	No	Transdermal drug patch?	Yes	No
Surgical Clips or wire sutures?	Yes	No	Electronic or mechanical implant?	Yes	No
Metal plates, rods, screws or pins?	Yes	No	Are you pregnant?	Yes	No
Radiation Treatment?	Yes	No	Are you breastfeeding?	Yes	No

CONSENT

I **DO / DO NOT** (please circle) consent to having Gadolinium Based Contrast (GBCA) used as part of my MRI examination

SIGNATURE: _____ **DATE:** _____

MRI OF UPPER EXTREMITY

Please read carefully and circle answers

Is this scan being performed because of an injury? YES ☐ NO ☐

If yes, when was the injury _____

Have you had surgery to the area we are going to scan? YES ☐ NO ☐

If yes, please explain what was done and where _____

Which side is affected? Right ☐ Left ☐ Both ☐

Where is the pain generally located? Shoulder ☐ Upper Arm ☐ Forearm ☐ Elbow ☐ Wrist ☐

If you have pain, is it most painful on the: Inner side ☐ Outer side ☐ Front ☐ Back ☐

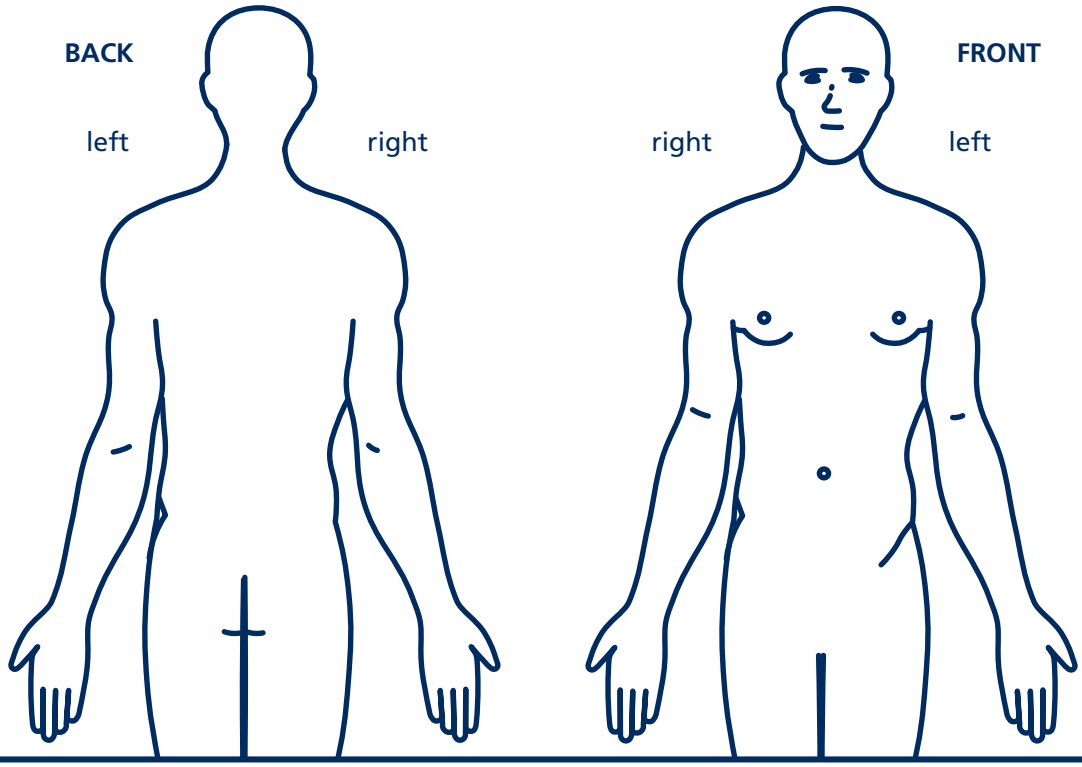
If you have no pain, please describe briefly the problem/s which prompted you to visit your doctor resulting in this test being done?

Have you experienced any of the following?

Locking?	Never ☐	Sometimes ☐	Often ☐
Clicking?	Never ☐	Sometimes ☐	Often ☐
Giving way?	Never ☐	Sometimes ☐	Often ☐
Numbness?	Never ☐	Sometimes ☐	Often ☐

Do you have any other medical problem/s which may be relevant to this scan?

Please indicate the area affected by shading the picture.



Please Complete Both Sides