NHS
Sherwood Forest Hospitals
NHS Foundation Trust

MRI (Magnetic Resonance Imaging) Safety Questionnaire
Telephone Number - 01623 622515 ext 6190

Name_____ **Address**_____ _____ **DOB**_____	**IMPORTANT** **PLEASE WRITE YOUR NAME ON THIS FORM.** **COMPLETE THE QUESTIONS AS SOON AS POSSIBLE AND BRING THE FORM WITH YOU** **RING US IF YOU ANSWER YES TO ANY OF QUESTIONS 1-9** **FAILURE TO RING US MAY MEAN WE WILL BE UNABLE TO SCAN YOU ON YOUR APPOINTMENT DAY**

HAVE YOU EVER HAD ANY OF THE FOLLOWING (CIRCLE ANSWER)

1. A Cardiac/Heart PACEMAKER or Implanted Defibrillator fitted?	**YES**	**NO**
2. Surgery to your heart? e.g. cardiac stent, heart valve, Reveal/Confirm/Implantable Cardiac Monitor	**YES**	**NO**
3. Surgery on your head, brain, ears, eyes? e.g. aneurysm clip, hydrocephalus shunt, cochlear implant, detached retina.	**YES**	**NO**
4. Surgery on your spine?	**YES**	**NO**
5. Metal fragments in your eyes, or any part of your body e.g. a penetrating eye injury or a shrapnel injury	**YES**	**NO**
6. An operation involving the use of any magnetic, mechanical or electronic implant? e.g. non-cardiac stent, gastric band, breast implant, porta Cath, plates, screws, replacement joints, renal stent or clips, medicine pump, vibrant sound bridge, PillCam?	**YES**	**NO**
7. Any surgery, procedure or tattoo in the last 2 months?	**YES**	**NO**
8. Are you or could you be pregnant?	**YES**	**NO**
9. Are you currently breastfeeding?	**YES**	**NO**
Have you had any other surgery? **If yes, list operation/procedure and the year.**	**YES**	**NO**
Have you had an MRI scan before? Year Hospital	**YES**	**NO**
Fits, blackouts, epilepsy?	**YES**	**NO**
CONTRAST/BUSCOPAN/MANNITOL ONLY **Allergies, hay fever, asthma?** **Diabetes, any known kidney problems**? **Myasthenia gravis, cardiac problems, high/low BP, paralytic ileus, toxic megacolon or acute angle glaucoma**?	**YES**	**NO**
Wear a hearing aid, removable metal dentures, Libre diabetic monitor or coloured contact lenses?	**YES**	**NO**

Your HEIGHT_____ **cm or** _____**ft** _____**ins** **WEIGHT**_____**kg or st**_____**lbs**_____

Please contact us if your weight exceeds 20 stones (127 kilos)

PLEASE DO NOT BRING VALUABLES AND METAL OBJECTS WITH YOU

You will need to remove all metallic objects, e.g. hearing aids, metal dentures, silver dressings, watches, coins, keys, credit cards, jewellery (except wedding rings), hair grips, glasses, skin patches, body piercings, libre devices and eye make-up before the scan.

PAINKILLERS

If you normally take painkillers, please take them. It is important that you are comfortable and keep still for your scan. Moving blurs the pictures. We are unable to supply any medication or sedation.

TRANSPORT

If you have organised hospital transport, please make sure your appointment is between 10-4 Mon to Fri.

CONSENT - CONTRAST MEDIA/BUSCOPAN INJECTION & MANNITOL

I understand that the doctor supervising my study may decide I need an injection of intravenous contrast, the need for an injection of contrast medium will be discussed at the time of the examination.

I **DO / DO NOT** consent to the MRI examination.

I **DO / DO NOT** to an injection of contrast media.

I **DO / DO NOT** consent to an injection of Buscopan.

I **DO/DO NOT** consent to drinking 1500ml, 2.5% Mannitol solution prior to my small bowel MRI.

FOR MRI STAFF USE ONLY - PLEASE DO NOT SIGN THIS FORM UNTIL YOU ARE ASKED TO

3-point ID CHECK completed by;	MRI Radiographer (Initials)	3-point ID CHECK confirmed by;	Name of ward staff/carer or relative identifying the patient. For ward inpatients does the wrist band also match?

By signing below, you (the patient/on behalf of the patient) acknowledge that you have had the procedure explained to you and that you answered the questions overleaf correctly to the best of your knowledge.

Patient / Parent / Guardian / Relative	
Questions checked by Assistant	
Questions checked by MRI Radiographer	
Date	

PATIENT ID LABEL

MRI SEQUENCES

BLOODS Date_____ Creatinine_____ eGFR_____

CANNULA/BUTTERFLY Wrist band used ☐

Site L / R AC / Wr / Hand

Inserted by_____ Time in_____ Flushed by_____

Removed by_____ Time out_____

Administered Medicine Administered By_____

Sticker or Batch No/Exp Date

Prohance ☐ Dose_____ml_____

Gadovist ☐ Dose_____ml_____

Primovist ☐ Dose_____ml_____

Sod. Chloride ☐ Dose_____ml_____

Posiflush ☐ Dose_____ml_____

Buscopan ☐ Dose_____ml_____

Mannitol ☐ Dose_____ml_____

PGD version_____ Patient Info Leaflet given ☐