SickKids®

Department of Diagnostic Imaging

MRI Screening Form for Patients

WARNING: The MRI magnet is always ON!
The MRI machine has a very strong magnetic field. Patients and visitors must be screened prior to entry into the MRI room.

LAST NAME FIRST NAME

MRN VISIT NUMBER

DATE OF BIRTH DD-MM-YYYY SEX

ADDRESS

IMPRINT OR ENTER DETAILS BY HAND

For urgent Inpatient and Emergency cases to be booked, this form must be completed, signed, and dated. Send the completed form by tube (135) or fax to MRI Reception at ext. 205789. We **cannot** book patients until we receive this form. Incomplete forms will delay care. For any questions or concerns, call MRI at 416-813-5774 (press 3).

These questions must be answered prior to entering the MRI room:

1. Has the patient ever worked with metal or welding **without** goggles or face shield? ❑ Y ❑ N
2. Has the patient ever had a penetrating injury to the eye? ❑ Y ❑ N
3. Has the patient ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel)? ❑ Y ❑ N
   If yes, please describe where and how: _____
4. Could the patient be pregnant? First day of last menstrual period: _____ ❑ Y ❑ N
5. Has the patient had any surgeries/procedures:
   On the head, eyes, or brain? ❑ Y ❑ N
   On the neck, spine or back? ❑ Y ❑ N
   On the heart, lungs, or chest? ❑ Y ❑ N
   On the abdomen or pelvis? ❑ Y ❑ N
   On the arms or legs? ❑ Y ❑ N

If yes, please list **all** surgeries/procedures at SickKids, especially those before June 2018:

Date: _____ Type: _____ Implant used: ❑ Y ❑ N

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Date: _____ Type: _____ Implant used: ❑ Y ❑ N

Were any surgeries/procedures done at another hospital? ❑ Y ❑ N Implant used: ❑ Y ❑ N

If yes to outside implant, please ask your doctor for the name, material, catalog, and/or reference number:

_____

Please answer the following:

Metallic dental devices: ❑ None ❑ Palate expander ❑ Spacers ❑ Braces ❑ Metal caps ❑ Wire ❑ Other: _____

GI system devices: ❑ None ❑ G-tube ❑ C-tube ❑ J-tube ❑ Button

Please indicate if patient has any of the following:

Intravascular coil, clip, filter, or stent	❑ Y	❑ N	Wire or mesh implant	❑ Y	❑ N
Brain aneurysm clip(s)	❑ Y	❑ N	Metal rods, plates, screws, nails, or wires	❑ Y	❑ N
Cardiac pacemaker, ICD, or heart device	❑ Y	❑ N	External fixator	❑ Y	❑ N
Heart valve, septal occluder, or patch	❑ Y	❑ N	CGM device (Dexcom, FreeStyle Libre, Guardian)	❑ Y	❑ N
Electronic implant or device (VNS, DBS)	❑ Y	❑ N	EEG leads	❑ Y	❑ N
VP shunt ❑ Y ❑ N Programmable?	❑ Y	❑ N	Port-a-cath, PICC line, or central line	❑ Y	❑ N
Swan-Ganz or thermo-dilution catheter	❑ Y	❑ N	Transdermal medication patch	❑ Y	❑ N
Programmable internal pump (baclofen)	❑ Y	❑ N	Pill camera or patency capsule	❑ Y	❑ N
External medication or insulin pump	❑ Y	❑ N	Endoscopy clips? If yes, date: _____	❑ Y	❑ N
Myringotomy or ear tubes	❑ Y	❑ N	Intrauterine device (IUD) or similar	❑ Y	❑ N
Cochlear implant or implanted hearing device	❑ Y	❑ N	Coloured or tinted contact lenses	❑ Y	❑ N
Hearing aid	❑ Y	❑ N	Tattoos or body piercings	❑ Y	❑ N
Orbital/eye prosthesis or implants	❑ Y	❑ N	Magnetic eyelashes or makeup	❑ Y	❑ N
Tracheostomy tube	❑ Y	❑ N	Hair extensions, wig, clips, or pins	❑ Y	❑ N
Silver wound dressing	❑ Y	❑ N	Artificial or prosthetic limb or joint	❑ Y	❑ N
Electronic intracranial pressure (ICP) monitor	❑ Y	❑ N	External splints or braces	❑ Y	❑ N
Lumbar drain or external ventricular drain (EVD)	❑ Y	❑ N	Period panties or antibacterial/athletic clothing	❑ Y	❑ N

Is there anything in or on the patient they were not born with? _____

Form completed by: ❑ Patient ❑ Parent/Guardian ❑ Other – please specify: _____

Print name _____ Signature _____ Date (DD-MM-YYYY) _____ Time _____

DI RN if Sed/GA (sign): _____ **DI Tech (sign):** _____

Interpreter/Language Line Services used: ❑ Y ❑ N **Interpreter signature/ID number (if applicable):** _____