MRI SCREENING OF PATIENTS

THE HOSPITAL FOR SICK CHILDREN

WARNING: The MR system has a very strong magnetic field that may be hazardous to patients entering the MR environment if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. Therefore, this form must be completed for all MRI requests. Be advised: **the MR system magnet is ALWAYS on and all metallic objects must be removed before the patient enters the MR environment.** If you have any questions or concerns regarding an implant, device, object, or MRI patient screening please call the MRI department at 416-813-5774 (press 7).

ADDRESSOGRAPH

Please complete all sections on the day of examination

1. Has patient ever worked with metal or operated welding or grinding equipment? Y ❑ N ❑
2. Has patient ever had a penetrating eye injury? **If yes** to #1 or #2, please arrange for orbit x-rays before MRI and include Radiology report with request. Y ❑ N ❑
3. Has patient ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel, etc.)? Y ❑ N ❑
   If yes, please describe: _____
4. Could patient be pregnant? Y ❑ N ❑
5. Has patient ever had any kidney related problems? **If yes**, please indicate date and results of most recent blood work (creatinine):_____ Y ❑ N ❑
6. Has patient ever had a prior MRI examination? **If yes**, please describe if patient has experienced any problem related to previous MRI examination: _____ Y ❑ N ❑
7. Has patient had prior surgery / operation / invasive procedure (e.g. heart surgery, brain / eye surgery, orthopedic surgery, arthroscopy, endoscopy, etc.) of any kind? **If yes**, please indicate: Y ❑ N ❑

   Date _____ Type of surgery _____ Implants used _____

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Please indicate if patient has any of the following:

Surgical aneurysm clip(s)	Y ❑ N ❑	Artificial or prosthetic limb or joint	Y ❑ N ❑
Cardiac pacemaker / pacing wires	Y ❑ N ❑	Metal rods, plates, screws, nails, or wires	Y ❑ N ❑
Cochlear implant or implanted hearing device	Y ❑ N ❑	Wire mesh implant	Y ❑ N ❑
Implanted cardioverter defibrillator (ICD)	Y ❑ N ❑	Swan –Ganz or thermodilution catheter	Y ❑ N ❑
Electronic implant or device	Y ❑ N ❑	Implanted insulin or infusion pump or device	Y ❑ N ❑
Magnetically-activated implant or device	Y ❑ N ❑	Transdermal medication patch	Y ❑ N ❑
Neuro or bio stimulator device	Y ❑ N ❑	Dental implants / dentures or braces	Y ❑ N ❑
Heart valve replacement	Y ❑ N ❑	G tube / C tube / J tube / gastric button	Y ❑ N ❑
Any type of intravascular coil, filter, or stent	Y ❑ N ❑	Intra-uterine device (IUD)	Y ❑ N ❑
Any vascular clip including PDA clips	Y ❑ N ❑	Tattoos or body piercing	Y ❑ N ❑
Myringotomy / ear tubes	Y ❑ N ❑	Programmable pump e.g. Baclofen **(confirm status pre and post MRI)**	Y ❑ N ❑
Orbital / eye prosthesis or implants	Y ❑ N ❑	Programmable shunt **(must be re-programmed post MRI)**	Y ❑ N ❑
Coloured / tinted contact lenses	Y ❑ N ❑		
Hearing aid - **remove before entering MR system room**	Y ❑ N ❑		

ANY OTHER IMPLANT:

SCREENING

I attest that the above information is correct to the best of my knowledge. Form completed by (check): ☐ Patient ☐ Parent/Guardian

☐ Other _____ Date _____ Time _____

Name (print) _____ Signature _____

DI RN – if Sed/GA (sign) _____ DI Tech (sign) _____

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

REVISION DATE: SEP 22, 2011