MRI Safety Screening Form - Research

Name: DOB: NHI:

Height: Weight: Scan #

	YES	NO
Have you had a previous MRI scan?		
Do you have or have you **EVER** had a cardiac pacemaker or ICD *(Implanted Cardioverter Defibrillator?)*		
Have you **EVER** had an eye injury involving a metallic fragment? *If yes, was it removed?*		
Have you ever had any brain/head, inner ear or eye surgery? *i.e. Aneurysm clip, ventricular shunt, cochlea implant, ocular implant*		
Have you ever had heart surgery or vascular procedures? *i.e. heart valve, vascular stent or graft*		
Have you ever had any other surgery/operations? *Please list surgery and date:*		
Do you have any metallic, electronic, magnetic or other implants / devices? *i.e. Joint replacement, drug infusion device, neurostimulator, shrapnel / bullets?*		
Do you have any of the following?	**YES**	**NO**
Tattoos, permanent cosmetics or permanent make up		
Medicated skin patches – *Nicotine, hormone or silver dressings*		
Body piercings or acupuncture needles, pellets / seeds		
Hearing aids		
Dentures or partial plate		
Female Patients Is there any possibility you might be pregnant or breastfeeding?		

Consent for MRI

To the best of my knowledge the answers above are accurate and true, and I give my consent to proceed with my MRI scan.

Signature: **Date:** *MRT's Initials:*

If you answer YES or are uncertain regarding any of the above, please contact us on (09) 303 5966 prior to your appointment.