GUELPH GENERAL HOSPITAL

MRI PATIENT SAFETY FORM

Tel: 519-837-6440
Fax: 519-837-6423

PATIENT NAME________________________________ DOB______________

DATE________________________ HEIGHT__________ WEIGHT_____________

Please indicate Yes No for each of the following for the person having the MRI

	Yes	No		EXPLAIN
*Swan-Ganz Line	☐	☐	*No MRI	
*Cardiac Pacemaker / Pacing Wires	☐	☐	*No MRI	
History of metal in your eye,	☐	☐	* Need xray of orbits	
History of grinding / welding metal	☐	☐	* Maybe xray orbits	
Brain Surgery	☐	☐	Need OR reports	
Ear Surgery	☐	☐	Need OR reports	
Stent, filter, or coil	☐	☐	Need OR reports	
Implanted device anywhere in your body	☐	☐	Need OR reports	
Surgery in the last 6 weeks	☐	☐	Inform MRI tech	
Have you ever been shot	☐	☐	Inform MRI tech	
Pregnant	☐	☐	Inform MRI tech	
Surgery on your eyes	☐	☐	Inform MRI tech	
Joint replacement, screw, wire, plate	☐	☐	Location	
Claustrophobic / Anxiety disorder	☐	☐	Sedation /need driver	
Body piercing or jewellery	☐	☐	Remove prior to MRI	
Medication patch / insulin / infusion pump	☐	☐	Remove prior to MRI	
Kidney / Liver Disease / Diabetes	☐	☐	Need recent creatinine	
High blood pressure / more than 60 yrs of age	☐	☐	(Last 3 months)	
Do you have limited mobility, and / or require assistance	☐	☐	If yes please arrange to have someone come to your appointment with you	
Heart valve	☐	☐		
IUD, diaphragm, or pessary	☐	☐		
Tattoo or permanent makeup	☐	☐		
Hearing aid	☐	☐	Remove prior to MRI	
Dentures or partial plates	☐	☐	Remove prior to MRI	

Additional relevant information/previous surgeries

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The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. Therefore, all individuals are required to verify this form before entering the MR environment or MR system room. Be advised, the MR system magnet is **ALWAYS** on.

Patient Signature: ____ Date: ___________

* **If the patient is incoherent then the signature of substitute decision maker is required***

Substitute Decision Maker: ______________________________________ Date: ___________

Screened by: ____ Date: ___________

MRI Technologist: ____ Date: ___________