TARANAKI RADIOLOGY
A member of I-MED Radiology Network

3T MRI - PATIENT SAFETY QUESTIONNAIRE

SURNAME: ____________________________ FIRST NAME: ______________________________ DOB: _______________

ADDRESS: ____

EMAIL ADDRESS: ____ TELEPHONE: ___________________________

Certain implants, devices and objects may be hazardous to you or may interfere with the MRI examination
Please answer YES or NO to the following list of questions for your safety

HAVE YOU EVER HAD:			DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING: List A		
Brain Surgery	◯ Yes	◯ No	Cardiac Pacemaker or Implanted Defibrillator	◯ Yes	◯ No
Heart Surgery	◯ Yes	◯ No	Brain Coiling or Aneurysm Clip	◯ Yes	◯ No
Heart Stents	◯ Yes	◯ No	Cochlear Ear Implant / Stapes Ear Implant	◯ Yes	◯ No
Artifical Heart Valve	◯ Yes	◯ No	Neurostimulator Implant	◯ Yes	◯ No
Ear Surgery	◯ Yes	◯ No	Ventricular Brain Shunt	◯ Yes	◯ No
MRI Scan in the Past	◯ Yes	◯ No	Drug Pump / Monitor (Insulin, Pain medicine)	◯ Yes	◯ No
Metal Fragments in Your Eyes	◯ Yes	◯ No	Implanted Cardiac Monitoring System (Reveal LINQ)	◯ Yes	◯ No
if yes was it all removed by a doctor?	◯ Yes	◯ No	Cardiac Closure Device for Hole in Heart Repair	◯ Yes	◯ No
			Vascular Coils, Filters, Stents (Excluding Heart Stents)	◯ Yes	◯ No
DO YOU HAVE ON YOUR BODY:			Eye Prosthesis Containing Metal	◯ Yes	◯ No
Artifical Limb	◯ Yes	◯ No	Breast Reconstruction Tissue Expanders	◯ Yes	◯ No
Hearing Aids	◯ Yes	◯ No	Invisible Implanted Hearing Aids (eg Lyric)	◯ Yes	◯ No
Dentures / Dental plates	◯ Yes	◯ No	Joint Replacements Less than 6 Weeks Post Op	◯ Yes	◯ No
Wig / Hairpiece / Clip-in Hair Extensions	◯ Yes	◯ No	Pins/Plates/Screws/Rods Less than 6 Weeks Post Op	◯ Yes	◯ No
Nicotine / Medicine Patch on Your Skin	◯ Yes	◯ No	Operations in Last 6 Weeks with Metal Clips Inserted	◯ Yes	◯ No
Electronic Devices Attached	◯ Yes	◯ No	Shrapnel, Metal Fragments or Bullet Injury	◯ Yes	◯ No
Coloured Contact Lenses	◯ Yes	◯ No	Cosmetic Facial Tattoos	◯ Yes	◯ No
Dressings / Strapping Tape / Plasters	◯ Yes	◯ No	Recent Body Tattoos That are Not Fully Healed	◯ Yes	◯ No
Body Piercings	◯ Yes	◯ No			
Please remove ALL piercings prior to coming for your scan			IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE List A QUESTIONS		
			YOU MUST CONTACT TARANAKI RADIOLOGY TO DISCUSS BEFORE WE CAN		
PREGNANCY / BREASTFEEDING / CONTRACEPTIVE DEVICES			BOOK YOU IN FOR YOUR MRI SCAN		
Any Possibility You Could Be Pregnant	◯ Yes	◯ No	**Please Call 06 7594317 and Write Details Below:**		
(if yes please contact Taranaki Radiology on 06 7594317)			*LIST YOUR IMPLANTS / ADDITIONAL INFORMATION HERE:*		
Are You Currently Breastfeeding	◯ Yes	◯ No			
IUD/Mirena Coil/Contraceptive Device	◯ Yes	◯ No			
CLAUSTROPHOBIC PATIENTS:					
Are You Claustrophobic	◯ Yes	◯ No			
if yes please contact Taranaki Radiology on 06 7594317					

I attest that the above information is correct to the best of my knowledge. I have read and understand the questions:

Signature of Patient / Guardian / Other: ______________________________________ Date: ___________________

Please return this completed form to: Taranaki Radiology, MRI Magnet House, 59 Vivian Street, New Plymouth OR Scan form and email to booking.taranaki@i-med.co.nz

STAFF USE ONLY:

Questionnaire checked by MRI staff member: _________________________________ Height: ______________ CM.

Area to be scanned confirmed: ____ Weight: ______________ KG.