SouthlakeHealth

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MRI Patient Safety Screening Form

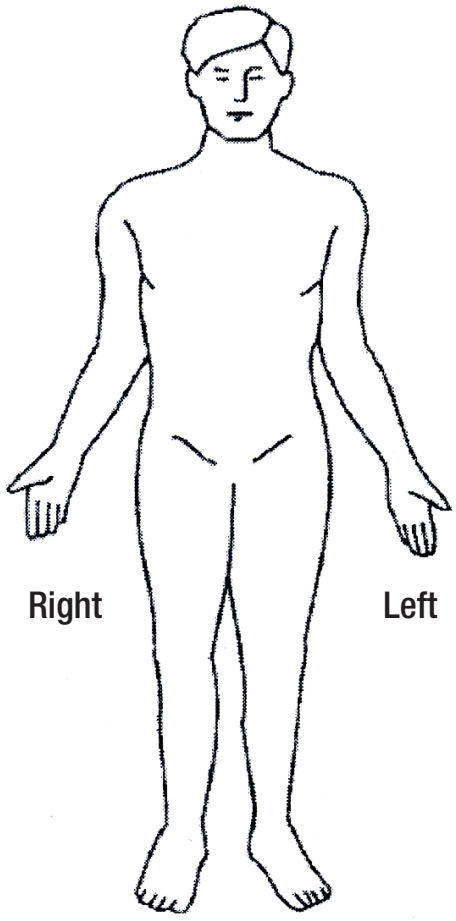
Please fax to (905) 830-5966

Patient Name: *(print first, last)*		**Date:** dd / mm / yy
Date of Birth: dd / mm / yy	**Height:**	**Weight:**

The following items may interfere with MR imaging and be hazardous to your safety. Please indicate with a (✓) check mark if you have any of the following:

	YES	NO
Cardiac pacemaker	❑	❑
Pacing wires (from previous pacemaker)	❑	❑
Cerebral aneurysm clips	❑	❑
Neuro or bio stimulator device	❑	❑
Swan Ganz line (or metallic wire/tip catheter)	❑	❑
Implanted insulin/chemotherapy pump	❑	❑
Cochlear (inner ear) implant	❑	❑
Heart valve replacement	❑	❑
Hearing aid	❑	❑
Orbital/eye prosthesis (cataract lens implant safe)	❑	❑
Tattoos	❑	❑
IUD	❑	❑
Any type of intravascular coil, filter, stent	❑	❑
Shrapnel (gunfire)	❑	❑
Dentures (or magnetic dental implant)	❑	❑
Artificial limb or joint	❑	❑
Transdermal Patches	❑	❑
Glucose monitoring sensor	❑	❑
Metal rods, plates, screws, nails, wires	❑	❑
Have you ever worked with metal?	❑	❑
Have you ever had metal in your eyes?	❑	❑
Are you pregnant?	❑	❑
Do you have a history of Kidney Disease?	❑	❑
Are you on Dialysis?	❑	❑

Please mark on this drawing, the location of any metal inside your body.



Any other metal in your body?
(including tissue expanders, endoscopy capsules) If yes, give details:

Previous surgeries: ❑ **Yes** *(please list)*
❑ **No**

Symptoms:

Patient Signature:	**Date:** dd / mm / yy
Substitute Decision-Maker Name: *(print first, last)*	**Date:** dd / mm / yy
Technologist Name: *(print first, last)*	**Date:** dd / mm / yy