

<p>Unique Identifier NO: RD.020.2013v2 Radiology Reference: MRIIPSQ</p> <p style="text-align: center;">Magnetic Resonance Imaging in Patient Questionnaire</p> <p>Status: Operational</p>	<p style="text-align: center;">(Patient ID Label)</p> <p>Name: DOB: NHS Number: Hospital Number:</p>	<p style="text-align: center;">Ward</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
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Ward **Postcode**..... **Weight**

In the MRI scan room there is a strong magnet. In the interest of safety please answer the following questions. You **MUST** place all metallic objects and any valuables in the locker provided **BEFORE** you enter the scan room.

	YES	NO
Do you have a pacemaker/artificial heart valve/implanted device? (e.g. implanted infusion pump)	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have angina or suffer from any heart disorders?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an operation to your head, eyes or ears?	<input type="checkbox"/>	<input type="checkbox"/>
Have you any aneurysm clips in your head or cochlea implants in your ears?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a hydrocephalus shunt? If yes, is it programmable?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had metal fragments in your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had surgery in the last 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any surgery on your spine?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any metal implants e.g. hip replacement, shrapnel?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear metal dentures or a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from epilepsy or are you diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently wearing any transdermal patches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any tattoos, permanent or semi-permanent make-up?	<input type="checkbox"/>	<input type="checkbox"/>
LADIES ONLY: Could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>

Unique Identifier NO: RD.020.2013v3
Radiology Reference: MRIIPSQ

Magnetic Resonance Imaging in Patient Questionnaire

Status: Operational

(Patient ID Label)

Name:
 DOB:
 NHS Number:
 Hospital Number:

Occasionally the radiographers are required to administer a contrast media (dye) injection in order to provide additional information to complete your scan. This carries a small risk of allergic reaction and we therefore require you to answer the following questions to enable us to carry out your examination as safely as possible

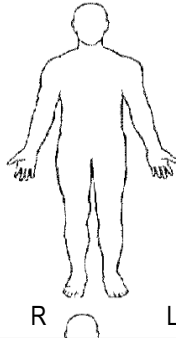
	YES	NO
Have you ever had an injection of contrast media before?	<input type="checkbox"/>	<input type="checkbox"/>
If so, did you have a reaction to it?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any known allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer form asthma, eczema, hay fever or heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from prostate problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from myasthenia gravis?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have kidney problems?	<input type="checkbox"/>	<input type="checkbox"/>

I confirm that I have read the above and it is a correct record to the best of my knowledge. I have been given a full explanation of the procedure and agree to its performance.

Patients Signature: _____ Date: _____
 Answers Verified by: _____ Date: _____
 Hospital Notes checked by: _____ Date: _____

Injection details

Name
 Lot No.
 Expiry
 Dose
 Injected by
 Reaction Yes/No
 Treatment:

IV & SC cannula insertion record		
Date:	Time:	Please indicate insertion site
Size:	IV or SC	
Ward:	No. of attempts:	
Reason for re-site:		
Inserted by:	Removed by:	
Contrast: 1 st check:	2 nd check:	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Cannula Label </div>
Saline: 1 st check:	2 nd check:	