Calderdale and Huddersfield NHS Foundation Trust

Unique Identifier NO: RD.020.2013v2 Radiology Reference: MRIIPSQ **Magnetic Resonance Imaging in Patient Questionnaire** **Status: Operational**	(Patient ID Label) Name: DOB: NHS Number: Hospital Number:	Ward

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)	☐	☐
Have you had any heart surgery?	☐	☐
Do you have angina or suffer from any heart disorders?	☐	☐
Have you ever had an operation to your head, eyes or ears?	☐	☐
Have you any aneurysm clips in your head or cochlea implants in your ears?	☐	☐
Do you have a hydrocephalus shunt? If yes, is it programmable?	☐	☐
Have you ever had metal fragments in your eyes?	☐	☐
Have you had surgery in the last 6 weeks?	☐	☐
Have you ever had any surgery on your spine?	☐	☐
Do you have any metal implants e.g. hip replacement, shrapnel?	☐	☐
Do you wear metal dentures or a hearing aid?	☐	☐
Do you suffer from epilepsy or are you diabetic?	☐	☐
Are you currently wearing any transdermal patches?	☐	☐
Do you have any tattoos, permanent or semi-permanent make-up?	☐	☐
LADIES ONLY: Could you be pregnant?	☐	☐
Are you breastfeeding?	☐	☐

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?	☐	☐
If so, did you have a reaction to it?	☐	☐
Do you have any known allergies?	☐	☐
Do you suffer form asthma, eczema, hay fever or heart problems?	☐	☐
Do you suffer from glaucoma?	☐	☐
Do you suffer from prostate problems?	☐	☐
Do you suffer from myasthenia gravis?	☐	☐
Do you have kidney problems?	☐	☐

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: