Unique identifier: PR 3000/026
Review Date: April 2028
Review Lead: Service Lead Radiology

IN PATIENT MRI SAFETY SCREENING QUESTIONNAIRE

Please complete this form **CAREFULLY**. Please also remember to remove all metallic objects and jewellery from your person before your appointment. Thank you

Name:			**D.O.B:**		
Address:			**Height**:		
MRN:			**Weight:**		
Could you be pregnant?	YES	NO	**DRIPS/INFUSION PUMPS?**	YES	NO
METHOD OF TRANSPORT?	CHAIR	BED	**DNAR in place?**	YES	NO
OXYGEN REQUIRED?	YES	NO	**IR?**	YES	NO

MRI STAFF ONLY: ID CHECK:

SECTION 1: Please tick if you have **EVER** had any of the following. If **YES** please give details:

Do you have or have **EVER** had:	**YES**	**NO**	**UNSURE**
Cardiac pacemaker, ICD, artificial heart valve, stents? When and Where?.....			
Surgery or procedures on your brain including aneurysm clips, coils and webs? When and Where?.....			
Surgical clips, shunts, stents, cochlear implants? ……			
Metallic fragments in your eyes? If **YES,** were they removed in hospital?.....			
Implanted medical devices e.g. nerve or bone stimulators, drug infusion device, hydrocephalus shunts, penile implants, breast tissue expanders, gastric bands……..			
Surgery in the last 6 weeks? When and what?.....			

SECTION 2: Do you have any of the following? Please tick

	YES	**NO**	**DETAILS**
Implanted heart monitor/loop recorder?			
Glucose monitoring system e.g. Libre sensor?			
Metal implants e.g. knee replacement or shrapnel?			
Medicine patches on your skin e.g. HRT/pain?			
Metal dentures or hearing aids?.....			
Do you suffer from epilepsy or diabetes?.....			
Hair extensions with metal/tattoos/magnetic cosmetics?			
If you have had a capsule endoscopy, has the capsule come out?			

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Occasionally the radiographers are required to administer a contrast media (dye) injection and/or Buscopan (an antispasmodic drug) in order to provide additional information and improve image quality. This carries a small risk of allergic reaction and we therefore require you to answer the following questions:

CONTRAST (Gadolinium based contrast agents)	**YES**	**NO**	**UNSURE**
Have you been told you have a reduced kidney function?			
Are you on kidney dialysis?			
If **Yes,** to either question, an up to date eGFR should be checked (within the last 3 months) and documented.	**eGFR……..ml/min/1.73m^2** **Date of eGFR……** **Staff initial…….**		

Have you ever had an injection of contrast media?			**Staff only:** Cannulation insertion details Pls stick here
If **YES**, did you have a reaction to it?			
Do you suffer from asthma, eczema or hay fever?			
Are you currently breastfeeding?			
Do you have any allergies? If **YES** to what?.....			
BUSCOPAN (Hyoscine butylbromide)	**YES**	**NO**	
Have you been told you have an arrhythmia (abnormal heart rhythm) or tachycardia (unusually fast heart rate)?			
Do you have unstable angina (use a GTN spray regularly)?			
Do you have myasthenia gravis or glaucoma			
Do you have/recently had a bowel obstruction/ileus?			
Do you have an enlarged prostate and/or urine retention?			

MRI Staff Only:

CONTRAST ADMINISTRATION	**BUSCOPAN ADMINISTRATION**
CONTRAST TYPE:	BATCH:
BATCH:	ADMINISTERED BY:
ADMINISTERED BY:	VOLUME:
VOLUME:	EXP DATE:
EXP DATE:	**CANNULA REMOVED BY**:

PATIENT DECLARATION:

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

PRINT NAME……SIGNATURE……Date……..

ANSWERS VERIFIED BY……GMC NUMBER……..Date……
EPR CHECKED BY ……Date……..

Contrast can only be given to a patient in accordance with the correct PGD. By giving contrast and completing this form you are indicating the patient meets the inclusion criterion for the PGD and contrast is being given in agreement with it. If a patient refuses consent for the injection this must be recorded here: