SOUTH COAST RADIOLOGY | MACKAY RADIOLOGY | DARLING DOWNS RADIOLOGY

PATIENT SAFETY AND CONSENT FOR MAGNETIC RESONANCE IMAGING (MRI)

FULL NAME: _____ **WEIGHT** (kg): _____

DATE OF BIRTH: _____ **HEIGHT** (cm): _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Any heart surgery? YES ☐ NO ☐

If yes, please provide details: _____

Any surgery involving metal implants? YES ☐ NO ☐

If yes, please provide details: _____

Any brain, ear or eye surgery? YES ☐ NO ☐

If yes, please provide details: _____

Any other surgery/procedure in the last 3 months? YES ☐ NO ☐

If yes, please provide details: _____

Have you had any previous imaging to this area? YES ☐ NO ☐

If yes, where and when? _____

DO YOU HAVE ANY OF THE FOLLOWING? (Please tick yes or no)

Cardiac pacemaker / Defibrillator?	YES ☐	NO ☐	Aneurysm clips?	YES ☐	NO ☐
Neurostimulator?	YES ☐	NO ☐	Stents, coils or vascular filter?	YES ☐	NO ☐
Electric or mecahnical implant?	YES ☐	NO ☐	Brain shunt?	YES ☐	NO ☐
Inner ear prosthesis?	YES ☐	NO ☐	Brest tissue expander?	YES ☐	NO ☐
Magnetically-activated implant or device?	YES ☐	NO ☐	Glucose monitoring device?	YES ☐	NO ☐
Implanted infusion device?	YES ☐	NO ☐	Body piercing or permanent jewellery?	YES ☐	NO ☐
Electronic bone growth/fusion stimulator?	YES ☐	NO ☐	Dentures or braces?	YES ☐	NO ☐
Surgical clips or wite sutures?	YES ☐	NO ☐	Transdermal drug patch?	YES ☐	NO ☐
Metal plates, rods, screws or pins?	YES ☐	NO ☐	Colonoscopy in the last 2 months?	YES ☐	NO ☐
Bullets, pallets, or metal foreign body?	YES ☐	NO ☐	Tattoos or permanent eye/lip liner?	YES ☐	NO ☐
Prosthetic joints or limbs?	YES ☐	NO ☐	Radiation treatment?	YES ☐	NO ☐
Hearing aid? (Must be removed before scan)	YES ☐	NO ☐	Liver transplant?	YES ☐	NO ☐
Metal in your eyes (at any stage)?	YES ☐	NO ☐	Kidney disease or renal impairment?	YES ☐	NO ☐
Epicardial or retained pacing wires?	YES ☐	NO ☐	Back surgery?	YES ☐	NO ☐
Heart valve replacement?	YES ☐	NO ☐	Any chance you are pregnant or brestfeeding?	YES ☐	NO ☐
Penile Implant?	YES ☐	NO ☐	Claustrophobia?	YES ☐	NO ☐

Injection of Gadolinium Based Agent (GBCA)

As part of your MRI examination, you may be required to have an injection of Gadolinium Based Contrast Agent (GBCA). This injection is given to improve the diagnostic quality of your scan if needed. If required, we would need to inject the GBCA into a vein. The injection usually has no side effects, however, may cause unwanted drug reactions in some people. These range from slight nausea, headaches, and dizziness. On extremely rare occasions allergic reations such as hives, skin reactions or anaphylaxis may occur. In a very small percentage of cases, people with poor renal function may be at risk of contracting Nephrogenic Systemic Fibrosis (NSF), which may affect the skin and internal organs. In cases of poor renal function GBCA would not be administered. Recent studies have shown that gadolinium can be retained by the body for significant periods after your examination. Currently no adverse effects of gadolinium retention have been identified.

ALLERGIES: YES ☐ NO ☐ If yes, please provide details _____

CONSENT: I DO ☐ DO NOT ☐ (please tick) consent to having Gandolinium Based Contrast (GBCA) used as part of my MRI examination.

SIGNATURE: _____ **DATE:** _____

STAFF USE ONLY

Contrast used and dose given:	Questionnaire checked by Technical Staff	Radiologist Consulted (if required)
	Sign _____	Sign _____