

MRI Safety Screening Questionnaire (English)

Information:

MRI is an examination where a strong magnetic field and radiowaves are used. Therefore it is of utmost importance that you fill out the questions below. If you answer one of these questions with 'YES', please contact the Radology Department on the following number (076) 595 10 86).

Please bring this form with you on the day of your appointment. If you forget this form, your examination could be delayed.

	Yes	No
• Do you have a cardiac (heart) pacemaker or ICD?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you got certain clips in your skull from brain operations e.g. aneurysmclips?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you ever worked with metal and had any metal fragments in your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you got a neurostimulator?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you got an insuliepump? If Yes, you can disconnect it yourself.	<input type="checkbox"/>	<input type="checkbox"/>
• Have you got any cochlear (ear) implants?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you had a heartvalve replacement?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you had surgery to your heart less then one year ago?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you had any operations that involve metal clips, pins, plates or implants?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you had any operations in the last three months?	<input type="checkbox"/>	<input type="checkbox"/>
• Have you had a ligament replacement e.g. Knee, Hip, Shoulder?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you have a dental replacement with magnets?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you suffer from claustrofobia?	<input type="checkbox"/>	<input type="checkbox"/>

• Are you allergic for certain medication? If yes, wich one?
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What is your lenght and what is your weight	cm	kg
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Don't forget to fill out and sign the back of this form!

To be filled in by female patients only:	Yes	No
• Do you have a contraceptive coil?	<input type="checkbox"/>	<input type="checkbox"/>
• Are you, or could you be, pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you breastfeed? If yes, you can pump your milk beforehand, so that your baby can drink this milk 24 hours after the examination. If you have had dye during the examination, you should pump the milk for 24 hours after the examination and throw this away.	<input type="checkbox"/>	<input type="checkbox"/>

By signing below, you acknowledge that you have read, understood and answered all of the above questions.

Name:

Date:

Signature:
