MRI Scan Department Pre Examination Questionnaire

Name:

Date of Birth:

Address:

Hospital Number:

PACEMAKER FORM

INPATIENT ID Check (you must make a 3 point ID check of the patient)

The ID check has been performed by ID Band: ☐

The ID has been checked against the patient record by: ……Radiographer

Ward:

Examination Time:

Weight: **Height:**

DNACPR status:

Not for CPR ☐
For full escalation ☐
Unknown ☐

Transport Chair MRI Trolley
Infection? No Yes ……
NOK Needed? Yes No
Porters Job No: **Locker No:**

Protocol & Vetting (you must check the vetting instruction on CRIS)

Protocol & Sequences:

Protocol checked by:

Scanned By:

Clinical History:

MRI Safety Questionnaire Prior to Scan			
	YES	NO	Unsure
Do you have a Cardiac/Heart Pacemaker or defibrillator (ICD)?			
Have you ever had any operations involving your head/your heart OR eyes?			
Have you had any operations/surgery in the last 6 weeks?			
Have you ever worked as a machinist, metalworker or welder?			
Have you ever had any metallic fragments in your eyes?			
Have you ever had any metal in your head or body e.g. shrapnel?			
Do you suffer/ have you suffered from a heart disorder/ fits/ blackouts/ epilepsy or diabetes?			
Have you any history of kidney problems?			
Do you have any of the following?			
Any implanted medical device e.g. Implanted drug infusion device, nerve or bone stimulator, cochlear implant, gastric bands, glaucoma shunts?			
Any type of prosthesis or implant? E.g. Eye, hip, knee, penile, cochlear etc.			
Shunts, lines, catheters, wires or stents?			
Dentures or plates?			
Hearing Aids?			
Artificial Limbs?			
Medicine Patch/Dressings e.g. HRT, nicotine, pain relief, silver dressing			
Tattoos?			
Are you happy to lock any valuables away? *(If yes please complete Property Form)*			
To be answered by Female Patients of Childbearing Age (12-50)			
Is there any possibility of pregnancy? LMP?			
Are you breast feeding?			

Patient Signature: _____ **Date:** _____

Checklist completed and Checked by: _____

Allergy Questions

(Delete as appropriate)

Do you have any Allergies? **Yes/No**

Do you have acute renal failure? **Yes/No**

Renal Function:

(Check renal parameters on HIS or CRIS event comments)

eGFR: ml/min/1.73^2 **……..**

Serum Creatinine: µmol: **……..**

Sample Date: **……./……./…….**

Authorisation to administer IV Contrast by Radiologist (If required)

Name of Radiologist: Signature:

Questions Prior to Buscopan Injection

(Delete as appropriate)

Tachycardia or Heart Disease?	**Yes/No**	**Allergy to Hyoscine Butylbromide?**	**Yes/No**
Glaucoma?	**Yes/No**	**Prostate Problems? (Men Only)**	**Yes/No**
Megacolon	**Yes/No**	**Pregnant/Breast Feeding (Women Only)**	**Yes/No**
Myasthenia Gravis?	**Yes/No**	**Overactive Thyroid Gland?**	**Yes/No**
Intestinal Obstruction?	**Yes/No**	**Pyrexia (Fever)**	**Yes/No**

Buscopan				
Volume Injected: ml	Batch Number:	Expiry Date:	Injected By:	Checked By:

Record of Medicine Administration:

Sodium Chloride 0.9% used for:		**Intravenous Contrast Agents :**	
Checking Cannulae Patency **5mls** *(repeat dose as required)*		**Gadovist**	**Volume Injected :** **ml**
"Saline Bolus Chase" **Total Volume Injected:**	**ml**	**Other Contrast** Name :	**Volume Injected :** **ml**

Batch Number:		**Batch Number:**	
Expiry Date:		**Expiry Date:**	
Injected By:		**Injected By:**	
Checked By:		**Checked By:**	

Check **all** images are on PACS: ☐ Allocate to reporting list: ☐ Documents scanned in on CRIS: ☐