Centre universitaire de santé McGill McGill University Health Centre

Magnetic Resonance (MRI) Safety Screening & Consent Form

Patient information :

MUHC CENTRALE DE RDV/APPOINTMENT CENTRE
imaging.appointment@muhc.mcgill.ca
MUHC RDV /Appt.Fax. 514.843.1301 **Tel.:** 514.934.4434
Lachine RDV Tel.: 514.934.1934 Ext. 38092
MNH Tel.: 514.398.8510 **Fax.:** 514.398.2829

Results to: **Address:**
Tel: Fax:

Have you ever had

Kidney problem or family history of kidney disease	no☐	yes☐	**If yes, creatinine level is required. CR:** _____
Severe liver disease or kidney transplant	no☐	yes☐	**If yes, creatinine level is required. CR:** ________
Diabetes or hypertension	no☐	yes☐	**If yes, creatinine level is required. CR:** ________
Brain Surgery	no☐	yes☐	
Heart or coronary bypass surgery **	no☐	yes☐	**(** If yes, a Chest x-ray is required before the MRI)**
Retained epicardial pacer wires **	no☐	yes☐	
Other surgery	no☐	yes☐ ⇨	Specify:______________________________

Do you have a

Cardiac Pacemaker	no☐	yes☐	Pessary or IUD	no☐	yes☐
Implanted cardiac defibrillator	no☐	yes☐	Body piercing	no☐	yes☐
Heart valve prosthesis	no☐	yes☐	Tattoo / permanent make-up	no☐	yes☐
Implanted insulin pump	no☐	yes☐	Halo vest or Cervical		
Implanted chemo therapy pump	no☐	yes☐	fixation devices	no☐	yes☐
Endovascular stent	no☐	yes☐ ⇨	Specify type:____________________Model:__________		
IVC filter ‹ 3 months	no☐	yes☐			
Cerebral aneurysm clip	no☐	yes☐ ⇨	Specify type:______________________________		
Cerebral Ventricular Shunt	no☐	yes☐ ⇨	Specify type:______________________________		
Neurostimulator or Biostimulator	no☐	yes☐ ⇨	Specify type:______________________________		
Ocular, otologic or dental implant / device	no☐	yes☐ ⇨	Specify type:______________________________		
Penile implant	no☐	yes☐ ⇨	Specify type:______________________________		
Implanted orthopedic device	no☐	yes☐ ⇨	Specify type:______________________________		
Internal or external colored contact lenses	no☐	yes☐			
Are you claustrophobic?	no☐	yes☐	Are you pregnant?	no☐	yes☐

Have you ever been injured by a metallic body

**To the eyes ** **	no☐	yes☐ ⇨	Was it removed?	no☐	yes☐
**To another part of the body ** **	no☐	yes☐ ⇨	Specify type:______________________________		

**** If yes, an X-ray of the area in question is required prior to the MRI Exam**

IMPORTANT NOTE: If you wear any type of medication skin patch, it must be removed before your exam. Please bring a fresh patch with you to put on after your exam.

I have reviewed the above safety screening form with my physician, it is correct and complete and I consent to have the MRI examination.

______________________ ______________ ______________________
Physician signature **Date** **Patient signature**

For Radiology Use Only: 1 2 3 4 5

Protocol