BC Children's Hospital
Provincial Health Services Authority

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

# MRI PATIENT SCREENING FORM

Write info or use Patient Information Sticker

Name:
MRN:
DOB:
PHN:

**THIS FORM MUST BE COMPLETED ACCURATELY. IF THE FORM IS MISSING OR INCOMPLETE, MRI WILL NOT BE BOOKED.**

**WARNING! MRI CANNOT BE PERFORMED IF PATIENT HAS ANY OF THE FOLLOWING:**

✖ Cardiac pacemaker ✖ Aneurysm clip ✖ Cochlear implant ✖ Metallic foreign body in eye

**DEPARTMENT USE ONLY** Height: _____ Weight: _____ Head circumference ≤ 6y of age: _____

**PLEASE LIST ALL ALLERGIES:**

| **HAVE YOU HAD SURGERY INVOLVING:** | **INITIAL SCREENING** | | **DEPARTMENT USE ONLY SECOND SCREENING** | |
|---|---|---|---|---|
| | **YES** | **NO** | **YES** | **NO** |
| Head/Neck/Eyes/Dental | ☐ | ☐ | ☐ | ☐ |
| Spine | ☐ | ☐ | ☐ | ☐ |
| Chest | ☐ | ☐ | ☐ | ☐ |
| Abdomen | ☐ | ☐ | ☐ | ☐ |
| Limbs | ☐ | ☐ | ☐ | ☐ |

***IF YES, please indicate:***

| *Date* | *Type of Surgery* | *Implants used* |
|---|---|---|
| *Date* | *Type of Surgery* | *Implants used* |

| | | | | |
|---|---|---|---|---|
| **History of Kidney disease or failure? If YES, date & results of creatinine:** _____ | ☐ | ☐ | ☐ | ☐ |
| **PLEASE INDICATE IF PATIENT HAS ANY OF THE FOLLOWING:** | **YES** | **NO** | **YES** | **NO** |
| **Braces, retainers, dentures, implants, palate spreader** | ☐ | ☐ | ☐ | ☐ |
| Cardiac pacemaker, wires, internal defibrillator | ☐ | ☐ | ☐ | ☐ |
| Artificial Heart Valve | ☐ | ☐ | ☐ | ☐ |
| Brain aneurysm clips | ☐ | ☐ | ☐ | ☐ |
| Any intravascular coils or stents | ☐ | ☐ | ☐ | ☐ |
| Cochlear implant or implanted hearing device | ☐ | ☐ | ☐ | ☐ |
| Programmable shunts (e.g., programmable must be re-programmed post MRI) | ☐ | ☐ | ☐ | ☐ |
| Prosthesis (e.g., artificial eye, limb/joint) | ☐ | ☐ | ☐ | ☐ |
| Tissue expanders or endoscopy capsule | ☐ | ☐ | ☐ | ☐ |
| Any penetrating eye injury involving metal? | ☐ | ☐ | ☐ | ☐ |
| Metal rods, plates, pins, screws, wires or nails | ☐ | ☐ | ☐ | ☐ |
| Injury by metallic object or retained foreign body (bullet, shrapnel) | ☐ | ☐ | ☐ | ☐ |
| Have you worked with metal? (e.g., welding or grinding) | ☐ | ☐ | ☐ | ☐ |
| Implanted drug infusion device (e.g., insulin, baclofen) | ☐ | ☐ | ☐ | ☐ |
| Neuro or bio stimulator device (e.g., vagal nerve, TENS unit, DBS) | ☐ | ☐ | ☐ | ☐ |
| Could you be pregnant? Date of LMP _____ | ☐ | ☐ | ☐ | ☐ |
| Diaphragm / IUD | ☐ | ☐ | ☐ | ☐ |
| Claustrophobia Select Level Here *Mild 1 2 3 4 5 6 7 8 9 10 Severe* | ☐ | ☐ | ☐ | ☐ |
| Transdermal Medication Patch (e.g., hormone, nicotine) | ☐ | ☐ | ☐ | ☐ |
| Tattoos, body piercings or permanent makeup | ☐ | ☐ | ☐ | ☐ |

**Initial Signature:** _____ **Date:** _____ ***DEPARTMENT* Signature:** _____ **Date:** _____

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| PATIENT PREPARATION | | | |
|---|---|---|---|
| Patient changed into hospital gown/scrubs<br><br>*ensure patient is wearing cotton undergarments **ONLY** | ☐ Y | ☐ N | ☐ N/A |
| Hair is clean/removal of hair clips | ☐ Y | ☐ N | ☐ N/A |
| Remove makeup/nail polish | ☐ Y | ☐ N | ☐ N/A |
| Remove jewellery/piercings | ☐ Y | ☐ N | ☐ N/A |
| Topical Anesthetic applied<br>☐ Ametop<br>☐ Emla<br>☐ Maxilene<br><br>Time: _____ | ☐ Y | ☐ N | ☐ N/A |
| **IV** | | | |
| Date and Time | | | |
| # of attempts | | | |
| Site | | | |
| Size | | | |
| Bloodwork drawn | | | |
| IV Discontinued @ _____ by _____ | | | |
| **Contrast** | | | |
| Contrast given: _____ | Amount (mls):_____ | | |
| Time given: _____ | Given By: _____ | | |
| **Reviewing MR Technologist Name & Date:** | | | |
| **Screening Notes:** | | | |
| **Movie:** _____ | | | |

| "Time Out" MRI Safety Check | |
|---|---|
| ☐ | Correct Patient/Parent |
| ☐ | Staff Check – No Metal |
| ☐ | Patient/Parent check – No Metal |
| ☐ | Equipment Check – MRI Safe Equipment |

| PARENT/GUARDIAN | | |
|---|---|---|
| **HAVE YOU HAD SURGERY INVOLVING:** | **YES** | **NO** |
| Head/Neck | ☐ | ☐ |
| Spine | ☐ | ☐ |
| Chest | ☐ | ☐ |
| Abdomen | ☐ | ☐ |
| Limbs | ☐ | ☐ |
| PLEASE REPORT ANY OF THE FOLLOWING: | **YES** | **NO** |
| Cardiac pacemaker, wires, internal defibrillator | ☐ | ☐ |
| Artificial Heart Valve | ☐ | ☐ |
| Brain aneurysm clips | ☐ | ☐ |
| Any intravascular coils or stents | ☐ | ☐ |
| Cochlear implant or implanted hearing device | ☐ | ☐ |
| Prosthesis (artificial eye, limb/joint) | ☐ | ☐ |
| Tissue expanders or endoscopy capsule | ☐ | ☐ |
| Any penetrating eye injury involving metal? | ☐ | ☐ |
| Metal rods, plates, pins, screws, wires or nails | ☐ | ☐ |
| Injury by metallic object or retained foreign body | ☐ | ☐ |
| Have you worked with metal? (e.g. welding) | ☐ | ☐ |
| Implanted drug infusion device (e.g. insulin) | ☐ | ☐ |
| Neuro or bio stimulator device (e.g., vagal nerve) | ☐ | ☐ |
| Braces, retainers, dentures, implants, spacer | ☐ | ☐ |
| Could you be pregnant? | ☐ | ☐ |
| Diaphragm / IUD | ☐ | ☐ |
| Transdermal Medication Patch (e.g., hormone) | ☐ | ☐ |
| Tattoos, body piercings or permanent makeup | ☐ | ☐ |

**Parent/Guardian signature** _____

**Second signature**_____**Date:** _____