Place patient sticker **within** this box

NHS
Royal Cornwall Hospitals
NHS Trust

MRI safety screening form for patients who lack capacity

This form should be completed by the referring clinicians in cases where the patient is not able to complete it accurately themselves. It should be completed with reference to the patients medical notes, previous medical imaging and where possible in consultation with the patients next of kin.

Once completed please send to the MRI department in advance of the patients appointment. Late or incorrectly completed forms will result in a delay to the patients scan.

BE AWARE THAT INCORRECTLY COMPLETED FORMS COULD RESULT IN SERIOUS INJURY OR DEATH

Please answer the following questions		Yes / No
1	**Does the patient have or have they ever had a pacemaker?** **Does the patient have an artificial heart valve?** If yes: Manufacturer/model?	
2	**Have they ever had heart surgery?** If yes: What	
3	**Does the patient have a cerebral aneurysm clip?** **Have they ever had brain surgery?** If yes: What	
4	**Does the patient have a cochlear or other otologic/ear implant?** If yes: What	
5	**Do they have any prosthesis? eg: penile implant, joint replacement, artificial limb etc** If yes: What	
6	**Does the patient have or have they ever had a neuro stimulator? eg: dorsal column stimulator** **Does the patient have an implanted drug infusion device?** If yes: Manufacturer/model?	
7	**Do they have any electronic, mechanical or magnetically operated device?** If yes: What	
8	**Has the patient ever had vascular embolisation?** **Does the patient have any coils, stents, filters?** If yes: What	

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MRI SAFETY CHECKLIST cont...

Please answer the following questions		Yes / No
9	**Does the patient have a Swan-Ganz or thermodilution catheter?** **Does the patient have surgical staples/metallic sutures?** **Does the patient have any tissue expanders?** **Does the patient have a Shunt (intraventicular / spinal)?** **Does the patient have a programmable shunt?** **Has the patient had any surgery in the last 6 weeks?** If yes: What	
10	**Does the patient have history of ever having a metallic foreign body in the orbit?** If yes / unsure - Please request orbits X-ray	
11	**Does the patient wear a transdermal medication patch?** **Does the patient have a vascular access port?** If yes: What	
12	**Other implants?** If yes: What	
13	**Does the patient have impaired renal function?** STATE Recent eGFR:	
	WOMEN ONLY	
14	**Is the patient pregnant?** **Is the patient breast-feeding?** If yes, give details:	
	FOR ALL PATIENTS	
15	**Is the patient able to lie flat and motionless for at least 15 minutes?** If no, give details:	
16	**Does the patient suffer from claustrophobia?**	
17	**What is the patient's weight?**	

I confirm that I have answered all the questions and the information is correct to the best of my knowledge.

Please ensure all loose metallic objects, including metallic body piercing, hearing aids, foil drug patches and dentures are removed prior to the scan.

Name of referring Doctor completing the form: **Date:**
Signature:

Name of next of kin and relationship (where possible): **Date:**
Signature:

Name of Radiographer undertaking scan: **Date:**
Signature: