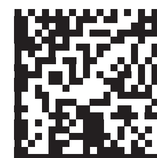
Place patient sticker **within** this box

Royal Cornwall Hospitals
NHS Trust

MRI safety checklist



Name:		**Date of birth:**
Address:		
Postcode:	**Telephone number:**	

	Please answer the following questions	**Yes / No**
1	**Do you have a cardiac pacemaker/defibrillator?**	
2	**Have you ever had a cardiac pacemaker/defibrillator?** If yes, give details	
3	**Have you ever had heart surgery? (eg: Valve replacement, Bypass,)** If yes, give details	
4	**Do you have a neuro-stimulator?**	
5	**Have you ever had any type of electronic, mechanical, or magnetic Implant?** If yes, give details	
6	**Have you ever had surgery to your brain?** If yes, give details	
7	**Have you ever had an aneurysm/blood vessel repaired in your brain?**	
8	**Do you have a programmable hydrocephalus shunt?**	
9	**Have you ever had surgery to your ears?** If yes, give details	
10	**Have you ever had surgery to your eyes?** If yes, give details	
11	**Have you ever had any operations involving the use of metal implants, plates, or clips?** eg: Stents Filters Wires Rods Pins Plates Coils Clips Grafts	
12	**Have you ever had any metal fragments in your eyes?** If yes, give details	
13	**Have you ever had any metal fragments in any other part of your body?** (eg: Shrapnel) If yes, give details	
14	**Have you had any surgery in any part of your body in the past 8 weeks?** If yes, give details	

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MRI SAFETY CHECKLIST cont...

		Yes / No
15	**Have you had any of the following tests in the last 8 weeks?** Colonoscopy Sigmoidoscopy Gastroscopy Endoscopy PillCam / Oral camera	
16	**Do you wear any health / diabetic monitoring systems?** (eg: Libre diabetic monitor) If yes, give details	
17	**Have you ever had breast implants OR tissue expanders fitted?**	
18	**Have you had any cosmetic / body modification procedures?** eg: Dermal piercings Microblading Magnetic eyelashes Hair extensions RFID implant	
19	**Do you have a gastric band?** (For weight loss or reflux**)**	
20	**Are you wearing any medication patches?** (eg: nicotine, HRT patch)	
21	**Do you have any wound dressings?**	
22	**Do you have a prosthetic limb, eye or other artificial device not already mentioned?** If yes, give details	
23	**Have you had a previous MRI scan?** If yes, when was the most recent?	
24	**Could you be pregnant?**	
25	**Are you currently breast-feeding?**	
26	**What is your weight?** **(Stones)**	**(Kilograms)**

I confirm that that the information I have provided is correct to the best of my knowledge.

Signature of patient:	**Date:**
Signature of staff member (1):	**Date:**
Signature of staff member (2):	**Date:**

Please remove all loose metallic objects, including metallic body piercing, hearing aids, foil drug patches and dentures.

Question No:	Staff comments