

MR Safety Screening And Consent Form

The MR room contains a very strong magnet. Before you are allowed to enter, We must know if you have any metal in or on your body. Some metal objects can interfere with your scan or even be dangerous. Please answer the following questions carefully.

- | | | |
|--|---------|--------|
| 1 Have you ever had an operation or surgical procedure of any kind ? | () Yes | () No |
| 2 have your ever had an MRI done befofe ? | () Yes | () No |
| 3 Previous metal removal from eye? | () Yes | () No |
| 4 Are you pregnant or possibly pregnant ? | () Yes | () No |

DO YOU HAVE ANY OF THESE ITEM IN OR ON YOUR BODY ?

- | | |
|--|--|
| () Brains Clips | () Ear Implants |
| () Pacemaker | () Artificial valve |
| () Electrical Stimulator | () Infusion pump |
| () Intra-uterine device | () Coil, filter, or stent in your blood vessel |
| () Bullet, pellets or sharpnel Dentures | () Surgical clips, staples or wire sutures |
| | () Charm needles |
| | () Orthopaedic hardware-(plates,screw,pins,rod,wires) |

Notes : Please remove dentures, mascara (MR Head), hair clips, watches, credit cards an any loose metal before entering the MRI room

Patient's Name	_____	Date	_____
NRIC / PP No	_____	Telephone	_____
Date od Birth	_____	Weight	_____

MRI CONSENT

I consent to under go the MRI procedure and the administration of intravenous contrast agent on myself/child/ward named :

Patient's/Guardian's Signature

Witnessed By

Date

Date

..... *Allergies () Yes () No Asthma () Yes () No

List all Past operation or surgical procedure of any kind with dates :

Date:	Operation/Surgical Procedures

