London Health Sciences Centre

Department of Medical Imaging

MRI Patient Checklist

Label Here

DATE (YYYY/MM/DD):_____ ☐ IP ☐ OPD

DO YOU HAVE:	**YES**	**NO**	**DESCRIPTION/ COMMENTS/ IMPLANT MAKE & MODEL**
Heart pacemaker, pacemaker wires, heart valve, ICD, or loop recorder			
Stents - cardiac, carotid or vascular			
Vascular (umbrella) filter for blood clots or carotid artery clamp			
Brain aneurysm clips			
Embolization Coils			
Shunt (programmable or non-programmable)			
Implanted electronic devices, neuro-stimulators or bio-stimulators (tens unit)			
Tissue expander			
Artificial prosthesis and/or joints			
Ear implants (cochlear or stapes prosthesis)			
IUD or pessary implant			
Shrapnel, bullet or welding wounds			
Previous eye injury involving metal? (metal still present or been removed)			
Infusion/medication pump, glucose monitor			
Medication patch (e.g. Nicotine, Nitroglycerine, or diabetic)			
Holter /CardioSTAT monitor, dentures, body piercings, eyelash/hair extensions (MUST be removed)			
Permanent tattoo/eyeliner			
Is there any chance you could be pregnant?			
Have you had a previous MRI? Which hospital?			
Are you taking an iron medication called Feraheme?			
Any other implants we need to be aware of?			
Inpatients only: Pulmonary artery catheter/swan-ganz			
Temperature probe			
Armoured tracheostomy/endotracheal tube (MUST be plastic tube)			
Continuous monitoring EEG leads (leads MUST be MRI compatible)			

See Over →

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MRI CONTRAST INJECTION SCREENING:	YES	NO	DESCRIPTION/ COMMENTS/ IMPLANT MAKE & MODEL
Have you had a previous MRI with contrast dye?			
Have you ever had a reaction to MRI contrast?			
Do you have a history of asthma?			
Are you currently breastfeeding?			
Have you had chemotherapy within the last 2 days?			
Has your doctor ever told you that you have kidney problems?			
Are you currently on dialysis?			
Do you have diabetes?			
Do you have high blood pressure?			
Do you have any allergies? (e.g. environment, drug, food)_____			

Weight: _____ **Height:** _____

_____ **PRINTED NAME OF PATIENT / PATIENT'S SUBSTITUTE DECISION MAKER**

_____ **SIGNATURE OF PATIENT / PATIENT'S SUBSTITUTE DECISION MAKER (SDM)**

_____ **RELATIONSHIP OF SUBSTITUTE DECISION MAKER**

_____ **INFORMATION TAKEN OVER THE PHONE OR VERBALLY BY**

_____ **INFORMATION SOURCE**

_____ **SIGNATURE OF NURSE / PHYSICIAN IF PATIENT/SDM UNABLE TO COMPLETE**

DEPARTMENT USE ONLY:

CONTRAST INFORMATION DISCUSSED WITH PATIENT: ☐ YES ☐ NO TECH INITIALS: _____

TECH/RAD NOTES:

SALINE LOCK:

OTHER DRUGS:

TECHNOLOGIST SIGNATURE: _____