MMI
MACQUARIE MEDICAL IMAGING

MRI OUTPATIENT SAFETY QUESTIONNAIRE

Name.. Weight:...........kg Age:..............

Patient status: Private Workers compensation Overseas Visitor AMA rate

Quoted price:.........................(All DVA or workers compensation examinations written approval prior to being scanned) **Does the patient have any of the following? (**If any of the **bold** questions are *Yes*, complete the MRI HR form)

Pacemaker-(all Pacemakers contraindicated at 3 Tesla)	☐ **Yes**	☐ **No**
Aneurysm and/or arteriole- venous malformation (AVM) clips	☐ **Yes**	☐ **No**
Surgically inserted drug infusion device i.e. diabetic or pain relief.	☐ **Yes**	☐ **No**
Bone or neurostimulator (device that helps repair bone or treat brain or pain disorder)	☐ **Yes**	☐ **No**
Any Surgically Inserted Device that monitors vital organs(i.e. loop recorders)	☐ **Yes**	☐ **No**
Any vascular Stents (Heart, Chest, Neck or abdomen)	☐ **Yes**	☐ **No**
Breast Tissue Expanders	☐ **Yes**	☐ **No**
Cochlear Implant or inner ear surgery	☐ **Yes**	☐ **No**
Brain shunt tubing	☐ **Yes**	☐ **No**
Have you ever had an eye injury	☐ **Yes**	☐ **No**
(If yes to eye injury, what was the cause)		
Metallic implants/joint replacements/rods or screws	☐ Yes	☐ No
Artificial heart valve	☐ Yes	☐ No
Are you wearing hormone or nicotine patches	☐ Yes	☐ No
Dentures or braces	☐ Yes	☐ No
Any metallic foreign bodies	☐ Yes	☐ No
Hearing aid	☐ Yes	☐ No
Could you be pregnant	☐ Yes	☐ No
Are you breast-feeding	☐ Yes	☐ No
Do you suffer from anxiety or claustrophobia	☐ Yes	☐ No
Do you have diabetes	☐ Yes	☐ No
Chronic kidney impairment	☐ Yes	☐ No
Polycystic Kidneys	☐ Yes	☐ No
Current or previous kidney infection	☐ Yes	☐ No
Kidney dialysis	☐ Yes	☐ No
Kidney transplant	☐ Yes	☐ No
Chronic Liver disease	☐ Yes	☐ No
Connective tissue disease (Scleroderma SLE)	☐ Yes	☐ No
High Blood pressure	☐ Yes	☐ No
Vascular disease (previous heart attack or stroke)	☐ Yes	☐ No
Are you allergic to MRI contrast agent	☐ Yes	☐ No
Do you have allergies	☐ Yes	☐ No
(If yes to allergies, what are they)		

*Contrast injections may be required to complete your MRI examination: This does not mean there is anything wrong. The injection (dye) is a contrast medium. There can be side effects but they are extremely unusual. As with any medical procedure, a minimal risk still exists. The chance of a serious life-threatening reaction is less than 1 in 200,000.

I confirm that I understand and have carefully answered all of the above questions and I give permission for the MRI to proceed with the injection if required.

Signed: ______________________________ Date: ______________

Checked: ______________________________

Insurance and Research patients only:

Consent for the release of information: I hereby consent to the release of information concerning my examination to the responsible insurance company, solicitor or research group:

Name:________________________ **Signature:**____________________

MAGNETIC RESONANCE IMAGING (MRI)
QUESTIONNAIRE

What is the reason you are having an MRI scan today? (Please include recent or new complaints)

____

____

What are your major symptoms? (i.e. limited movement, lump, infection etc.)

____

____

How long have you had these symptoms? Days ☐ Weeks ☐ Months ☐ Years ☐

Did the problem develop suddenly or gradually? Suddenly ☐ Gradually ☐

Is the problem related to an injury?

Yes ☐ No ☐ Unknown ☐ If yes, date of injury: ____________________

Is the problem a sports related injury?

Yes ☐ No ☐ Unknown If yes, date of injury:____________________

Do you have a lump? Yes ☐ No ☐ If yes, where? __________________

Have you had any surgery to the area we are scanning? Yes ☐ No ☐

If yes, please list type of surgery and date(s): ____________________________________

____

Do you have a history of cancer? Yes ☐ No ☐ If yes, what type? ____________________

Did the treatment include: Radiation Therapy? Yes ☐ No ☐
Chemotherapy? Yes ☐ No ☐

If yes to radiation therapy, what part of your body and when? ________________________

Have you had previous imaging studies of the area being scanned today? Yes ☐ No ☐

If yes, Date:_______________ Facility:____________________________________

Type of study: X-ray ☐ CT ☐ Bone Scan ☐ MRI ☐ Other ______________________