Bay Radiology

IANZ ACCREDITED RADIOLOGY SERVICE ACCREDITATION NUMBER: 22

**0800 467 4260** **P** 07 578 0273 **E** info@bayradiology.co.nz
PO Box 2636, Tauranga 3144, Bay of Plenty, New Zealand

Site:
Date:
Time:
GP:

# MRI Safety Questionnaire

Please complete all green sections and answer all questions on both sides.

**Name** **Male / Female**

**DOB** **Weight (kg)** **Height**

| | | Please circle | |
|---|---|---|---|
| 1 | Do you have a cardiac pacemaker? | Yes | No |
| 2 | Have you EVER had metal fragments in your eyes?<br>If 'yes' please specify type of injury and year occured: | Yes | No |
| 3 | Do you have shrapnel or bullet fragments in your body? | Yes | No |
| 4 | Have you ever had surgery on your heart?<br>If 'yes' please specify the type and date of the operation: | Yes | No |
| 5 | Have you ever had surgery on your brain or spine?<br>If 'yes' please specify the type and date of the operation: | Yes | No |
| 6 | Have you ever had surgery on your eyes or ears?<br>If 'yes' please specify the type and date of the operation: | Yes | No |
| 7 | Have you had a colonoscopy within the last month? | Yes | No |
| 8 | Do you have any stents, eg biliary, aortic, ureteric (JJ) or coronary? | Yes | No |
| 9 | Do you have any of the following?<br>If 'yes' please specify the type and date of the operation: | Yes | No |

| | | | | | |
|---|---|---|---|---|---|
| | Aneurysm Clips/Coils | | Retinal Repair | | Joint Prosthesis |
| | Nerve Stimulator | | Breast Implant | | Silver Dressing |
| | Programmable Shunt | | Copper IUCD | | Medication Patch |
| | Defibrillator | | Heart Valve | | Other (please specify) |
| | Cochlear Implant | | Pins/Plates/Screws/Clips | | |

| | | | |
|---|---|---|---|
| 10 | Are you claustrophobic? (if 'yes' please consult with your GP to obtain a sedative if required) | Yes | No |
| 11 | Do you have any cosmetic tattoos or recent tattoos? | Yes | No |
| 12 | Are you pregnant or breastfeeding? | Yes | No |

**I have read and understood the contents of this form and to the best of my knowledge the information above is correct.**

Patient/Guardian Signature: Date:

MRI Staff Signature: Date:

**IF YOU HAVE ANSWERED 'YES' TO ANY OF THE ABOVE,**
**PLEASE PHONE US AS IT MAY PREVENT YOU FROM BEING SCANNED.**

please continue over page...

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# Informed Consent for Dotarem injection

To complete your MRI scan today it may be necessary for us to give you an injection via an IV line in your arm of a contrast agent called Dotarem (gadolinium based agent). Reactions to this contrast agent are rare, but it is our responsibility to ensure that you are fully informed.

A mild reaction (in 1-10% of people) may occur, such as nausea, headache, rash or injection site irritation. A more severe reaction (in less than 0.5% of people) is unlikely, but possible. This could include difficulty in breathing or a drop in blood pressure and may require medical treatment.

Your doctor, who has requested this examination, is aware of these risks and has recommended this test knowing that the potential benefits of the examination outweigh the risks involved with the injection of this contrast agent.

**Please circle**

| **Do you agree to have this injection, should it be necessary?** | **Yes** | **No** |
|---|---|---|
| Do you have any problems with kidney function? | Yes | No |
| Do you suffer from any allergies? | Yes | No |
| If yes please list: | | |
| Do you have asthma? | Yes | No |

| Patient/Guardian Signature: | Date: |
|---|---|

# Oral sedation for claustrophobia

If you require oral sedation for claustrophobia, please contact your GP and arrange this prior to your MRI scan. Your GP will instruct you how long it requires to take effect.

**I acknowledge that I have been advised not to drive today as I have taken medication that may impair my ability to drive safely.**

| Patient/Guardian Signature: | Date: |
|---|---|

# To be completed by MRI staff only

| Contrast requested by: | | Batch number: |
|---|---|---|
| Contrast administered and checked by: | | Expiry date: |
| Contrast amount (0.2ml/kg): | | IV Luer site: |
| eGFR: | Date: | Gauge: |
| MRI Technologist Signature: | | Date: |