# MRI Request & Safety Form

**Paul Strickland Scanner Centre**
**Mount Vernon Hospital**
**Northwood**
**Middx HA6 2RN**
Tel: 01923 844953 Fax: 01923 844 600

**Trial Name/No**____________________
**Scan Schedule Day**_________________
**Week**____________________________
**Standard of Care** ☐
**Commercial** ☐
**Local** ☐
**NCRN** ☐
**RECIST YES/No Other:**____________

| | |
|---|---|
| Surname: | **Date of request:** |
| First Name: | PP / NHS |
| Address: | NHS No: |
| | Hosp. No: |
| | Ref Hosp / GP Surg: |
| Postcode: | OP / IP/ Ward: |
| Telephone no 1: | Own Transport / Hospital Transport |
| Telephone no 2: | Ambulance / Chair / Trolley |
| DoB: / Male / Female | **Date form received:** |

**Examination Required**

| | | | | | | |
|---|---|---|---|---|---|---|
| Brain / BOS / IAMs | | Pelvis Staging | | Shoulder | RT | LT |
| Head & Neck | | Pelvis Bony | | Wrist | RT | LT |
| Brachial Plexus | | Whole Body | | Hips | RT | LT |
| Axilla | | C Spine | | Knee | RT | LT |
| Thorax or Cardiac | | T Spine | | Ankle | RT | LT |
| Abdomen or Liver | | L Spine | | Other: | | |

Reason for Scan:

Clinical Details:

Provisional Diagnosis:

Surgery Performed (date):

Previous RT/Chemo (date):

**You are responsible for informing the centre if the patient is an infection control risk:**

…………………………..

| Renal Impairment | Yes No | Previous Imaging | Date | Place |
|---|---|---|---|---|
| Urea: | | MRI | | |
| Creatinine: | | PET/CT | | |
| Date: | | CT | | |

| | | |
|---|---|---|
| Pacemaker | Yes | No |
| Pregnant | Yes | No |

Scanned by:

Archived by :

The Patient consents to their images being used for:

- Education ☐
- Research ☐
- Neither ☐

Patient's signature________________________________

Referring Consultant/GP:______________________________

Referrer's signature:____________________________

Name: ______________________Bleep No__________

**N.B. This form is a legal document**

**Please ensure that the patient fills in the safety questionnaire on the reverse.**

# MRI SAFETY QUESTIONNAIRE

Name: ______________________________Date of Birth________________

**These questions are necessary for your safety.** Please tick Yes or No

| | YES | NO |
|---|---|---|
| Have you got a pacemaker, defibrillator or programmable shunt? | | |
| Have you had **ANY** heart surgery e.g. bypass or heart valve surgery? | | |
| Have you **EVER** had surgery on your brain e.g. shunts, clips on your arteries or blood clots removed? | | |
| If you have a shunt is it programmable? | | |
| Have you **EVER** had metal fragments in your eyes even if the fragments have been removed? | | |
| Have you had a cataract operation? | | |
| Do you have **ANY** shrapnel or bullet injuries? | | |
| Have you had **ANY** surgery or biopsies? | | |
| Have you had a hernia operation? | | |
| Do you have any metal or electronic implants e.g. ear implants, joint replacements, pins, clips, plates or screws? | | |
| For women of childbearing age, could you be pregnant? | | |
| Do you have an IUD/COIL? | | |
| Have you had a sterilisation or a hysterectomy operation? | | |

**If you have answered YES to any of the above questions please ring the MRI unit now. You could save yourself a wasted journey.**

| | | |
|---|---|---|
| Do you have dentures or a hearing aid? | | |
| Do you suffer from epilepsy? | | |
| Do you have any tattoos, piercing or permanent eyeliner? | | |
| Are you breast-feeding at the moment? | | |
| Do you have any allergies? | | |
| Do you suffer from asthma, eczema or hay fever? | | |
| Have you got a history or family history of glaucoma? | | |
| Do you have chest, heart or kidney problems? | | |
| Are you a diabetic? | | |

It is important that you remove all metal objects such as hair slides, jewellery, metallic body piercing and watches for your scan. Please leave as many of these items at home as possible. Keys, money and credit cards must be kept outside of the scanning room.

**IF YOU HAVE ANY QUESTIONS, PLEASE RING THE MRI UNIT ON 01923 844953**
**Please sign below if you have understood and answered all the questions.**

Patient signature______________________________ Date__________________

Questionnaire checked by_________________________Date__________________

| Date | Drug | Dose | Route | Doctor's Signature | Time Given | Batch No. | Expiry Date | Rad |
|---|---|---|---|---|---|---|---|---|
| | **Gadovist** | | | | | | | |
| | **Sodium Chloride BP (0.9% w/v)** | | | | | | | |
| | | | | | | | | |