

UHN - MRI Screening Questions

PATIENT NAME: _____	NO	YES
Have you had a previous MRI?		
Has metal ever gone into your eye?		
Do you have any kidney disease?		
Are you on dialysis?		
Is there a chance of pregnancy? Last Menstrual Period:		
Do you have any of the following:		
Aneurysm Clips		
Artificial Cardiac Valve		
Cardiac Pacemaker		
Cochlear Implants		
Coils / Stents		
Neurostimulator		
Retained Pacing Wires		
Contrast dye allergy?		
Claustrophobia?		
Height _____ Weight _____		
DO YOU PERMIT THE CHRISTIE CLINIC STAFF TO SIGN YOUR COMPLETED QUESTIONNAIRE ON YOUR BEHALF ON THE MRI REQUISITION?	☐	☐

List surgeries below.

If Yes to implant, indicate details: (date implanted, make, model)

North York General Hospital - MRI Screening Questions

PATIENT NAME: _____	NO	YES
1. Pacemaker (or transvenous pacemaker wires) –absolute contraindication		
2. Intracranial Aneurysm Clip? (see 15, details required)		
3. Any type of Eye or Ear implant surgery? (see 15, details required)		
4. Any type of heart surgery? (Cardiac valve/stent) (see 15, details required)		
5. Any type of Mechanical/Magnetic Implant? Stimulator/insulin pump? Type? _____ (see 15, details required)		☐
6. Any type of Stent? Type? _____ (see 15, details required)		
7. Have you worked with metal (welder/grinder) or had metal in your eye?		
8. Did you have or are you going to have an endoscope in the 6 weeks prior to appointment?	☐	☐
9. Shrapnel/Bullet? (where?)		
10. Medicated patch? Type?		
11. Is there a chance of pregnancy? Last Menstrual Period:		
12. Claustrophobia?		
13. Contrast dye allergy?		
14. Height _____ Weight _____		
DO YOU PERMIT THE CHRISTIE CLINIC STAFF TO SIGN YOUR COMPLETED QUESTIONNAIRE ON YOUR BEHALF ON THE MRI REQUISITION?		

14. List surgeries below.

15. * If Yes to implant, indicate details: (date implanted, make, model)

SUNNYBROOK - MRI Screening Questions

PATIENT NAME: _____	NO	YES
Have you had a previous MRI?		
Previous allergic reaction to an MRI contrast agent?		
Is there a chance of pregnancy? Last Menstrual Period:		
Claustrophobia?		
Quadriplegia/Paraplegia (requires assistance to move)		
Ambulance or Wheeltrans transportation		
Metallic Orbital Foreign Body (metal in your eye)		
If yes, was it removed by a physician		
Other Metallic foreign body/shrapnel** (ie. bullets)		
Do you have any of the following:		
Implanted Cardioverter Defibrillator (ICD)		☐
Cardiac Pacemaker		☐
Cochlear/Otologic Implant*(excluding hearing aid).		☐
Cerebral Aneurysm Clip(s)*		☐
Magnetic or Electronically Activated Implant/Device**		☐
Metallic Stent/Filter/Coil**		☐
Tissue Expander*		☐
Intrauterine Device (IUD)**		☐
Orthopaedic Hardware or Prosthesis**		☐
Insulin or Other Infusion Pump		☐
Transdermal Patch**		☐
Height _____ Weight _____		☐
DO YOU PERMIT THE CHRISTIE CLINIC STAFF TO SIGN YOUR COMPLETED QUESTIONNAIRE ON YOUR BEHALF ON THE MRI REQUISITION?	☐	☐

List surgeries below.

If Yes to implant, indicate details: (date implanted, make, model)

St Michael's Hospital - MRI Screening Questions

PATIENT NAME: _____	NO	YES
Have you ever had an eye injury from a metal object or required a metal fragment to be removed by a doctor?	☐	☐
Are you on dialysis?	☐	☐
Is there a chance of pregnancy? Last Menstrual Period:	☐	☐
Claustrophobia?	☐	☐
Allergy to contrast dye?	☐	☐
Height _____ Weight _____	☐	☐
<i>Do you have any of the following:</i>		
Implanted Cardioverter Defibrillator (ICD)	☐	☐
Drug infusion pump (insulin, antibiotic, etc...)	☐	☐
Electronic monitoring device (diabetes, etc...)	☐	☐
Neurostimulator/TENS unit	☐	☐
Breast tissue expander	☐	☐
Cochlear or other ear implant,	☐	☐
Eye prosthesis or implant	☐	☐
Swan Ganz line	☐	☐
Shrapnel, bullet, foreign metal object	☐	☐
Brain aneurysm clip	☐	☐
Metal rods, pins, screws, wires	☐	☐
Intravascular stent, filter, coil	☐	☐
Other metallic implants (specify...)	☐	☐
Programmable Shunt	☐	☐
<i>DO YOU PERMIT THE CHRISTIE CLINIC STAFF TO SIGN YOUR COMPLETED QUESTIONNAIRE ON YOUR BEHALF ON THE MRI REQUISITION?</i>	☐	☐

List surgeries below.

If Yes to implant, indicate details: (date implanted, make, model)

St. Joseph's Health Center (Toronto) - MRI Screening Questions

PATIENT NAME: _____	NO	YES
Cardiac Pacemaker or pacing wires YES NO *** If yes to above, then contraindication to MR exam		
Aneurysm Clip		
Heart Valve Replacement		
Neuro-stimulator or residual wires		
Cochlear Implant		
Intrauterine Device		
Hearing Aid		
Medication Patches		
Shrapnel or Bullets		
Surgical Rods or Staples		
Prosthesis (limb, joint, eye, ear)		
Body Piercing/Jewellery		
Other Implanted Devices:		
Have you EVER cut, welded or ground metal?		
Have you EVER had metal in your eye?		
If yes to above, was it since your last MR exam?		
Is there a chance that you might be pregnant?		
Are you claustrophobic?		
Brain aneurysm clip		
Metal rods, pins, screws, wires		
Intravascular stent, filter, coil		
Other metallic implants (specify...)		
Programmable Shunt		
Height _____ Weight _____		
DO YOU PERMIT THE CHRISTIE CLINIC STAFF TO SIGN YOUR COMPLETED QUESTIONNAIRE ON YOUR BEHALF ON THE MRI REQUISITION?	☐	☐

List surgeries below.

If Yes to implant, indicate details: (date implanted, make, model)

HUMBER RIVER HOSPITAL - MRI Screening Questions

PATIENT NAME: _____	NO	YES
Possibility That You Are Pregnant		
Any Injury Ever to Your Eye(s) From a Metal Object		
Any Injury Ever From a Metal Object (eg., Bullet, Shrapnel)		
Cardiac Pacemaker		
Implanted Cardioverter Defibrillator		
Intracranial Aneurysm Clips		
Surgical Staples, Surgical Clips, Metallic Sutures		
Metallic Filter, Stents, Coils, Shunt		
Neuro/Bio-Stimulator, Drug Infusion Pump		
Electronically or Magnetically Activated Device		
Vascular Access Port, Catheter		
Artificial Heart Valve		
Tissue Expander		
Orthopedic Hardware (eg., Joint Replacement)		
Prosthetic Device (eg., Limb, Penile, Eye, Ear)		
Intrauterine Device, Diaphragm, Pessary		
Body Art (eg., Tattoos, Permanent Makeup, Body Piercings)		
Dental Appliance (eg., Dentures, Braces, Retainer, Plates)		
Medication Patch (Specify) _____		
Claustrophobia?		
Allergy to contrast dye?		
Height _____ Weight _____		
DO YOU PERMIT THE CHRISTIE CLINIC STAFF TO SIGN YOUR COMPLETED QUESTIONNAIRE ON YOUR BEHALF ON THE MRI REQUISITION?		

List surgeries below.

If Yes to implant, indicate details: (date implanted, make, model)

TRILLIUM HEALTH PARTNERS / CREDIT VALLEY - MRI Screening Questions

PATIENT NAME: _____	NO	YES
Have you ever had a previous MRI?		
Have you ever worked as a metal grinder or welder?		
Have you ever had a known injury to your eye with metal?		
Is there a chance you could be pregnant?		
Are you claustrophobic?		
<i>Do you have the following?</i>		
Cardiac pacemaker or leads still in place		☐
Cochlear or ear implants		☐
Eye surgery or implants (excluding contact lenses & cataracts)		☐
Cerebral aneurysm clips		☐
Heart valve replacement		☐
Shrapnel, bullets, ever been shot?		☐
Joint replacement or prosthesis		☐
Intravascular coil, filter or stent		☐
Surgical clips or staples		☐
Tissue expander		☐
Implanted devices, catheter, neurostimulators		☐
Vascular access port (Port-a-cath, swan ganz)		☐
IUD or diaphragm		☐
Medication patch on skin (nicotine, nitro)		☐
Penile prosthesis		☐
Hearing aid		☐
Piercings		☐
Tattoo or permanent make up		☐
Dentures		☐
Height _____ Weight _____		☐
<i>DO YOU PERMIT THE CHRISTIE CLINIC STAFF TO SIGN YOUR COMPLETED QUESTIONNAIRE ON YOUR BEHALF ON THE MRI REQUISITION?</i>		☐

List surgeries below or implants below (include date implanted, make, model)