The Ottawa Hospital | L'Hôpital d'Ottawa

MRI MEDICAL REVIEW

Please answer all questions carefully and completely. The following items can interfere with the MRI study and your safety.
Information must be provided by capable patient or family member with knowledge of patient history.

Weight:	Height:

	Yes	No	What, When, Where (if applicable)
Do you use a lift at home?			
Do you now, or have you ever, had a pacemaker or defibrillator?			
Have you had heart, ear or eye surgery?			
Have you had surgery for an aneurysm?			
Do you have an implanted pump, stimulator, electrodes or electronic device?			
Do you have stents, coils, filters, clips or grafts?			
Will you have had an endoscopy or colonoscopy procedure performed within 6 weeks prior to this appointment?			
Have you ever sought medical attention to have metal removed from your eyes?			
Is there a possibility you are pregnant?			
Are you on dialysis?			
Do you have diabetes, Lupus, history of kidney or heart disease, TIA, stroke or poor circulation to the legs or other parts (excluding varicose veins)? Please specify.			

Please list any allergies:

Please list all surgeries:

Do you have:	Yes	No	Do you have:	Yes	No
Breast implants/penile implant			A shunt or portacath		
Hearing aid			I.U.D. (Intrauterine device), diaphragm or pessary		
Permanent eye liner or tattoo			**Are you** breast feeding?		
Body piercing			**Have you** ever had an MRI?		
Nicoderm or medication patch			**If yes**, did you have an injection of contrast?		
Removable dental work			**If yes,** did you have any reaction to the contrast?		
Shrapnel/bullets					

Do you have any type of prosthesis or metal in your body that has not been covered in this questionnaire?

Are you taking medications for your heart, bronchitis, asthma or high blood pressure? ❑ Yes ❑ No
If yes, please list them:

Signature of person who completed the form	Relationship to patient	Date (yyyy/mm/dd)

Was this information provided by the patient? ❑ Yes ❑ No **If no,** please specify:

Name:	Relationship to patient:

To be completed by technologist

eGFR calculated value (if applicable) _____ Date of blood test (yyyy/mm/dd): _____

The risk of the contrast/exam has been explained to the patient, verbal consent was obtained and venipuncture performed by: _____

Questionnare reviewed by:	Injection performed by:	Contrast and dose:	Reaction? ❑ Yes ❑ No

Français au verso