

## 19 THE LANE, PAGET PG 05 BERMUDA

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## **MRI SCREENING FORM**

Date:		DD / MM / YY					
Patient Nan		me:	Date of Birth:D	D / MM / YY	_ Weight:	Height:	
Y or N							
$\bigcirc$	$\bigcirc$	HAVE YOU EVER WORKED WITH WELDING, METAL GRINDING OR BRAKES?					
$\bigcirc$	$\bigcirc$	HAVE YOU EVER HAD A PENETRATING INJURY TO YOUR EYE INVOLVING A METALLIC OBJECT?					
$\bigcirc$	$\bigcirc$	IF METAL WAS IN YOUR EYE, WAS IT REMOVED BY A DOCTOR?					
$\bigcirc$	$\bigcirc$	DO YOU HAVE TATTOOS OR PERMANENT EYELINER?					
$\bigcirc$	$\bigcirc$	DO YOU HAVE OCCULAR IMPLANTS?					
$\bigcirc$	$\bigcirc$	HAVE YOU HAD THE FOLLOWING? (Check those that apply)					
		CARDIAC PACEMAKER PACE WIRES CARDIAC CATHETER CARDIAC LOOP RECORDER					
$\bigcirc$	$\bigcirc$	IMPLANTED CARDIAC DEFIBRILLATOR (ICD)?	ı				
$\bigcirc$	$\bigcirc$	CARDIAC STENT (WITHIN LAST 4 WEEKS)?					
$\bigcirc$	$\bigcirc$	BRAIN SURGERY? WHEN?		WHERE?	TYPE?		
$\bigcirc$	$\bigcirc$	BRAIN ANEURYSM CLIP(S)? WHEN?		WHERE?			
$\bigcirc$	$\bigcirc$	CAROTID ARTERY VASCULAR CLAMP? WHEN	?		WHERE?		
$\bigcirc$	$\bigcirc$	COCHLEAR AND/OR STAPLES IMPLANTS? WH	HEN?		WHERE?		
$\bigcirc$	$\bigcirc$	SHUNT (INTRAVENTRICULAR OR SPINAL)?					
$\bigcirc$	$\bigcirc$	INSULIN OR INFUSION PUMP (INTERNAL/EXTERNAL?					
$\bigcirc$	$\bigcirc$	BONE GROWTH/FUSION STIMULATOR?					
$\bigcirc$	$\bigcirc$	NEUROSTIMULATORS (DEEP BRAIN VAGUS NERVE OR BLADDER STIMULATORS)?					
$\bigcirc$	$\bigcirc$	ANY PROSTHESIS (PENILE, ARTIFICIAL LIMB, OR BREAST EXPANDERS)?					
$\bigcirc$	$\bigcirc$	JOINT REPLACEMENT, SCREWS, PINS, RODS, STAPLES, METAL SUTURES, MESH IMPLANTS?					
$\bigcirc$	$\bigcirc$	DO YOU HAVE A HEARING AID (EXTERNAL OR IMPLANTED) MAGNETIC DENTURES TRANSDERMAL PATCH					
$\bigcirc$	$\bigcirc$	SWAN GANZ LINE (INTERNAL ONLY)?					
$\bigcirc$	$\bigcirc$	DO YOU HAVE ANY SHRAPNEL (BULLETS) IN YOUR BODY?					
$\bigcirc$	$\bigcirc$	DO YOU HAVE CLAUSTROPHOBIA? IF YES, ARE MEDS ORDERED FOR THIS? YES NO					
$\bigcirc$	$\bigcirc$	DO YOU HAVE ASTHMA OR ALLERGIES? HAVE YOU HAD A PREVIOUS REACTION TO MRI CONTRAST (GADOLINIUM)?					
Signature of PATIENT or Guardian Date:							