North Bay Regional Health Centre

Diagnostic Imaging

MRI Screening Information Form

Please answer all questions		**If Yes, describe briefly**
Is this a WSIB case? ☐ No ☐ Yes		WSIB Claim #:
Have you **EVER** had a metallic foreign body in your eye?	☐ No ☐ Yes	If yes, was it removed from your eye?
Are you pregnant or breastfeeding?	☐ No ☐ Yes	If yes, obtain informed consent
Do you have: cardiac pacemaker	☐ No ☐ Yes	
heart valve replacement	☐ No ☐ Yes	What type: Model #:
aneurysm clips	☐ No ☐ Yes	What type:
neuro-stimulator	☐ No ☐ Yes	
any implanted devices	☐ No ☐ Yes	Describe:
shunt (spinal or intraventricular)	☐ No ☐ Yes	
prosthesis (limb, joint, eye)	☐ No ☐ Yes	Where:
surgical rods or staples	☐ No ☐ Yes	Where:
diaphragm / IUD	☐ No ☐ Yes	Type:
hearing aid	☐ No ☐ Yes	
dentures / retainers	☐ No ☐ Yes	
shrapnel or bullets	☐ No ☐ Yes	Location:
tattoos / permanent make-up	☐ No ☐ Yes	Location:
body piercings / jewellery	☐ No ☐ Yes	If yes, all to be removed
medication patches	☐ No ☐ Yes	
Have you EVER had any surgery?	☐ No ☐ Yes	**Please list ALL surgeries and dates:**
Are you claustrophobic?	☐ No ☐ Yes	If yes, was any medication taken?
What is your current weight? kgs or lbs		What is your height?

I confirm the information provided above is true, and contraindications / risks of the procedure have been explained.

Date: ___________ Patient/Substitute Decision Maker Signature: ______________________________

Print Name: ______________________________

Date: ___________ Technologist Signature: ______________________________

Print Name: ______________________________