Magnetic Resonance (MR) screening form for patients

Version 2024-11-11

Name: _____ **Weight:** _____

Personal code number: _____ **Length:** _____

	YES	NO
1. Do you have a history of any of the following devices in your body? – Cardiac pacemaker or defibrillator – Implantable medicine pump (e.g. for insulin) – Implants for neurostimulation – Cochlear implant – Other electrical/magnetic activated implant or electrodes If YES, specify what: _____	☐	☐
2. Do you have any metal-containing items in your body? – Aneurysm clip or stent (in e.g. the heart or brain) – Other items, e.g. tracheal tube, tissue expander, coil, dental implants, prosthesis, screws, cardiac valve If YES, specify what: _____	☐	☐
3. Do you have any foreign metal objects in or on your body? – Metallic slivers or fragments in the eye – Shrapnels, bullets or pellets – Blood glucose sensor – Other foreign metallic objects If YES, specify what: _____	☐	☐
4. Are you pregnant?	☐	☐
5. Are you breast feeding?	☐	☐
6. Are you in dialysis or do you have a severe impaired renal function?	☐	☐
7. Have you ever had an allergic reaction to MRI contrast agents?	☐	☐
8. Do you suffer from claustrophobia? (fear of enclosed spaces)	☐	☐

Note! Please contact your MRI department **as soon as possible** if you have answered **YES** on any of the questions above

_____ _____

Signature by patient (>18 y), guardian, doctor or nurse **Date**

Is anesthesia monitoring needed? (Completed by referring doctor) ☐ ☐

The screening form is checked: _____

Signature MR staff

VÄSTRA GÖTALANDSREGIONEN

Telephone numbers

MR Sahlgrenska, Mölndal & Östra:
*031-342 34 60 (**mon-fri:** 8:30-11.00 & 13.00-14.00)*
***MR Drottning Silvias Barn- och Ungdomssjukhus**: 031-343 56 18*