MRI Patient Screening Questionnaire and Consent Form

NHS Lothian

SURNAME_____ FIRST NAME_____

DATE OF BIRTH_____ CHI_____

HEIGHT_____ WEIGHT_____

ADDRESS_____ HOME TEL_____

	Question	Yes	No
1.	Do you have a **CARDIAC PACEMAKER** or artificial **HEART VALVE**?		
2.	Have you **ever** had any operations on your **CHEST**, **HEART**, **HEAD** or **EYES**?		
3.	Do you have an **ANEURYSM CLIP**, **COCHLEAR IMPLANT** or **SHUNT**?		
4.	Have you **ever** in your life had an accident with metal, where **metal fragments** have gone into your **eyes** or body?		
5.	Are you wearing a MEDICAL patch e.g. Pain, Cardiac, HRT, Nicotine, Fentanyl?		
6.	**LADIES**: Could you be pregnant? Or are you breast-feeding?		
	If you answer YES to any of the questions 1-6 please contact the MRI department.		
7.	Have you **ever** had any surgery?		
8.	Have you had any surgery in the last **2 months**?		
9.	Do you have a **HEART CONDITION** or **KIDNEY DISORDER**?		
10.	Are you currently **EPILEPTIC** or **DIABETIC**?		
11.	Are you wearing **DENTURES**, **DENTAL PLATE**, **CONTACT LENSES** or **HEARING AID**?		
12.	Do you have any tattoos or piercings?		
13.	Do you have any metallic, electronic or foreign metallic objects in or attached to your body other than those mentioned above?		

I UNDERSTAND THE MRI EXAMINATION. I ALSO UNDERSTAND THE ABOVE QUESTIONS AND GIVE PERMISSION FOR THE USE OF INTRAVENOUS CONTRAST AGENT IF IT IS DEEMED NECESSARY.

I CONFIRM I HAVE REMOVED ALL METAL FROM MY PERSON.

SIGNATURE ..... DATE.....

(**Or signature of responsible adult**)

RADIOGRAPHER..... DATE.....

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To be completed by Hospital Staff

GADOLINIUM

GIVEN BY_____ AMOUNT GIVEN_____

Lot No: _____ EXPIRY DATE_____

COMPLICATIONS_____

SODIUM CHLORIDE

AMOUNT GIVEN_____ Lot No:_____

EXPIRY DATE_____

CONSENT FOR THE ADMINISTRATION OF HYOSCINE BUTYLBROMIDE (BUSCOPAN)

20 mg/ml to be administered intra-venously if no contraindications:

Myasthenia Gravis (muscle weakness)	Yes	No
Megacolon	Yes	No
Narrow angle glaucoma	Yes	No
Tachycardia	Yes	No
Prostatic enlargement with urinary retention	Yes	No
Paralytic Ileus (inactive gut)	Yes	No
Mechanical stenosis in the GI tract (blockage)	Yes	No
Pregnancy	Yes	No
Breastfeeding	Yes	No
Known sensitivity to Hyoscine Butylbromide or any of its components	Yes	No

The reason for the administration of Hyoscine Butylbromide and potential side effects have been explained to me, and I consent to its administration

Patient's Signature: _____

Administered by: _____ Date: _____

Vial checked by: _____

Lot No:_____ Expiry Date:_____