Ottawa and Eastern Ontario Hospitals
Fax MRI to Central Intake: 1 (613) 737-8944

MRI Screening Form
Tel: 1 (613) 737-8883

Every patient scheduled for an MRI Exam **MUST** complete the following questionnaire prior to being scanned.
Please answer each question accurately and explain any marked "yes".

Patient's last name	Patient's first name	Date of birth (yyyy/mm/dd)

Weight: kg	Height: cm	Please identify any special needs (i.e., sight, hearing impairment, interpreter etc.):

Known allergies:

WARNING: **If you plan on taking a sedative, you must have a driver with you or the exam will be cancelled. We ask that you remove all body piercings, jewelry, watches etc. before arriving to the MRI site.**
Certain implants, devices or objects may be hazardous to you or may interfere with the MRI procedure.

Please fill out the Screening Form as accurately as possible.	Yes	No	If YES, what, where, when (if applicable)
Do you have a cardiac pacemaker?	☐	☐	
Do you have an implanted defibrillator (present or past)?	☐	☐	
Have you had heart surgery (valve replacement, bypass etc.)?	☐	☐	
Do you have implanted clips, stents, coils, filters, grafts?	☐	☐	
Have you had surgery for an aneurysm?	☐	☐	
Do you have an electronic implant, wires or device, pump, stimulator?	☐	☐	
Have you had ear or eye surgery?	☐	☐	
Have you had an eye (ocular) injury?	☐	☐	
Are you on dialysis?	☐	☐	
Do you have implanted shunts, port-a-cath, catheter, Hickman, Swan Ganz, electrodes?	☐	☐	
Do you have an artificial implant (eye, penile etc.)?	☐	☐	
Any type of prosthesis or metal in your body?	☐	☐	
Have you had a colonoscopy or endoscopy within the last 6 weeks?	☐	☐	
Do you have diabetes or seizures, Lupus, history of kidney or heart disease, TIA, high blood pressure (hypertension), stroke or poor circulation to the legs or other parts (excluding varicose veins)?	☐	☐	
Do you have implanted shrapnel, bullets or pellets?	☐	☐	
Have you had a transplant?	☐	☐	

Please indicate Yes or No to any of the following:

	Yes	No		Yes	No		Yes	No
Are you claustrophobic?	☐	☐	Have you ever had an MRI scan before?	☐	☐	Radiation seeds?	☐	☐
Are you prone to falls?	☐	☐	If yes, were you injected with contrast?	☐	☐	Surgical rods, pins, screws or plates?	☐	☐
Any mobility issues?	☐	☐	Taking beta blockers?	☐	☐			
Medication patches?	☐	☐	Tattoo or permanent makeup?	☐	☐	Motion disorder?	☐	☐
Cochlear, hearing aid or ear implant?	☐	☐	Body piercing, jewelry?	☐	☐	Metallic cosmetics?	☐	☐
Dentures or partial plates?	☐	☐	Currently on chemotherapy?	☐	☐	Joint replacements?	☐	☐

For female patients:	Yes	No		Yes	No
Post-menopausal? If yes, date of last menstrual period (yyyy/mm/dd):	☐	☐	Are you currently breastfeeding?	☐	☐
Are you pregnant or the possibility of being pregnant?	☐	☐	Do you have an IUD or diaphragm?	☐	☐
Do you have breast implants, breast tissue expanders or pessary?	☐	☐			

The above information is correct to the best of my knowledge.

Name of person completing form or assisting patient (print)	Signature	Date (yyyy/mm/dd)

Form completed by:
☐ Patient ☐ Relative ☐ Power of Attorney

Relationship to patient: