



Hôpital général juif  
Jewish General Hospital

**MAGNETIC RESONANCE IMAGING**  
**PAVILLION D / ROOM D-205**  
**Tel. : (514) 340-8222, ext. 23777**

Unit #	
Last Name	
First Name	Maiden Name
Date of Birth	Telephone #
Medicare #	
Address	
WEIGHT _____ LBS/KG	
CLAUSTROPHOBIC? ____ YES ____ NO	

### QUESTIONNAIRE AND CONSENT FORM

**This questionnaire is to be completed by the physician and the patient and attached to the Radiology requisition before an MRI examination can be scheduled.**

Indicate the presence of:	YES	NO
Cardiac pacemaker (an absolute contra-indication).....	<input type="checkbox"/>	<input type="checkbox"/>
Clip on a cerebral aneurysm (absolute contra-indication).....	<input type="checkbox"/>	<input type="checkbox"/>
Ocular or cochlear implants (absolute contra-indication).....	<input type="checkbox"/>	<input type="checkbox"/>
Ocular foreign body (absolute contra-indication).....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac prosthetic valve (specify type) .....	<input type="checkbox"/>	<input type="checkbox"/>
Post coronary bypass graft (epicardial pacer wires).....	<input type="checkbox"/>	<input type="checkbox"/>
Brain surgery (specify) .....	<input type="checkbox"/>	<input type="checkbox"/>
Neuro stimulator (spine) .....	<input type="checkbox"/>	<input type="checkbox"/>
Metal prosthesis (specify) .....	<input type="checkbox"/>	<input type="checkbox"/>
Penile Implants (Omniphase, Decomed or specify).....	<input type="checkbox"/>	<input type="checkbox"/>
Other surgery (specify) .....	<input type="checkbox"/>	<input type="checkbox"/>
Is patient pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has patient ever been injured by a metallic body particularly to the eyes, at work or in other circumstances,? (Ex. Explosion, gun shot, accident at work, accident on the road, accident at war) <u>If yes, orbital x-rays will be required to assure the absence of a metallic foreign body</u>	<input type="checkbox"/>	<input type="checkbox"/>
Middle-ear prosthesis or hearing aid (s).....	<input type="checkbox"/>	<input type="checkbox"/>
Braces or removable dental work (fillings not-included)....	<input type="checkbox"/>	<input type="checkbox"/>
Vena-cava umbrellas (device used to prevent pulmonary emboli).....	<input type="checkbox"/>	<input type="checkbox"/>
Insulin infusion pumps (must be disconnected for MRI).....	<input type="checkbox"/>	<input type="checkbox"/>

I have reviewed the above questionnaire with my physician, it is correct and complete and I consent to the MR examination.

Physician signature \_\_\_\_\_

Patient signature \_\_\_\_\_

Date \_\_\_\_\_