



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.

<i>Indicate the presence of:</i>	YES	NO
Cardiac pacemaker (an absolute contra-indication) (If YES we require a photocopy of the Patient's Pacemaker card)	<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 _____