CAPE UNIVERSITIES BODY IMAGING CENTRE (CUBIC)
University of Cape Town
MRI Patient Screening Form

Patient Name: _____

Hospital/Clinic: _____

Date Of Birth: _____**Weight:**_____

Height:_____

The following information is very important to ensure your safety and to prevent any interference during MR procedure.

Please answer the following questions (mark with a X)

		Yes	No	Don't Know
1.	Do you have a cardiac pacemaker/defibrillator?			
2.	Do you have a neuro-stimulator?			
3.	Do you have cochlea implant/surgery to your ears? (If yes, please specify)			
4.	Have you ever had heart surgery such as a valve replacement? (If yes, please specify)			
5.	Have you ever had any type of electronic, mechanical, or magnetic implant? (If yes, please specify)			
6.	Do you have any foreign body in your eyes/body? Eg:(Bullet fragments etc)			
7.	Do you have a vena cava filter?			
8.	Do you have a prosthetic limb, eye/ other artificial device not already mentioned? (If yes, please specify)			
9.	Are you pregnant or breast feeding?			
10.	Are you claustrophobic?			
11.	Do you have aneurism clips?			
12.	Do you have renal impairment?			
13.	Do you have asthma?			
14.	Do you have allergies? (If yes, please specify)			
15.	Do you have other implants? Eg: (screws, plates, joint replacements)			
16.	Other			

I hereby acknowledge that the potential risks of the examination have been explained to me and during the course of investigation it may for the intravenous injection of a contrast agent.

ATTENTION: *It is the policy of this institution not to discuss results of MR Investigation with the patients for ethical reasons. All enquiries in this regard should be directed to the referring physician.*

Patient Signature:_____Date:_____

Consented by:_____

Please remove all loose metallic objects, including metallic body piercings, hearing aid and dentures