Welcome Back
MRI and Pain Management Centre

HRN Site: DOB: yyyy/mon/dd

Last Name First and Additional Names

PHN: Gender: Age in Years
Admitting Physician: Encounter #:

Patient History and MRI Screening
Department of Diagnostic Imaging

Address: Street, City, Province, Postal Code

Telephone Number:
Date of Admission: yyyy/mon/dd Family Physician:

Patient Weight	Patient Height	Date	Patient ID #

DO YOU HAVE...

	Yes	No	Unsure	Explain
Aneurysm clip(s), any type	☐	☐	☐	
Any IV access Port, type	☐	☐	☐	
Any type of coil, filter or stent in blood vessels?	☐	☐	☐	
Any type of implant held in place by a magnet?	☐	☐	☐	
Artificial Heart Valves?	☐	☐	☐	
Artificial limb or joint, any orthopedic item (ie pins, rods, screws, clips, wires, etc.) Location?	☐	☐	☐	
Body Piercing (other than earrings)? Location?	☐	☐	☐	
Breast Implants / Tissue expanders?	☐	☐	☐	
Cardiac (Heart) Pacemaker and wires?	☐	☐	☐	
Cerebral Intra-Ventricular shunt? Type?	☐	☐	☐	
Cochlear implant or other ear implant/hearing aid?	☐	☐	☐	
Dentures, retainers, braces, magnetic implants or any other removable dental items?	☐	☐	☐	
Diaphragm / IUD/ Pessary?	☐	☐	☐	
Electrical stimulator for nerves or bones? Type?	☐	☐	☐	
Implanted cardiac defibrillator?	☐	☐	☐	
Implanted Electrodes, Pumps or Catheters?	☐	☐	☐	
Lens implant or cataract surgery	☐	☐	☐	
Medication patch/dressing (ie: Nitroglycerin or Nicotine)	☐	☐	☐	
Metal in your eyes (at any time in your life)?	☐	☐	☐	
Neuro-Stimulators?	☐	☐	☐	
Orbital/eye prosthesis/eyelid springs?	☐	☐	☐	
Penile Prosthesis?	☐	☐	☐	
Renal shunt?	☐	☐	☐	
Shrapnel, Bullets or other metal fragments?	☐	☐	☐	
Tattoos or tattooed eyeliner (permanent makeup)	☐	☐	☐	

DO YOU HAVE...

Any Allergies?	☐	☐	☐	
Asthma?	☐	☐	☐	
Type I or II Diabetes?	☐	☐	☐	
History of Seizures or Convulsions?	☐	☐	☐	
Ischemic Cardiac disease (heart problems such as blocked arteries, history of heart attack)?	☐	☐	☐	
Kidney or Renal Disease?	☐	☐	☐	
Are you on dialysis: Hemo-dialysis or Peritoneal	☐	☐	Date of next appointment:	
Liver disease?	☐	☐	☐	
Peripheral vascular disease (problems with blood vessel circulation in arms and/or legs)?	☐	☐	☐	
Sickle Cell Disease or Hemolytic Anemia?	☐	☐	☐	
A history of Strokes? TIAs?	☐	☐	☐	
Do you have Nephrogenic Systemic Fibrosis (NSF)?	☐	☐	☐	
Are you Claustrophobic?	☐	☐	☐	

Have you **ever** had a surgical procedure or operation? Yes☐ No☐

List all surgeries _____ Year

MRI staff to fill out if Patient has: renal failure and/or is on Renal Dialysis.
Creatinine level_____ GFR_____
Date collected:_____
Checked with Radiologist: Dr. _____ ☐N/A
Rad. Consult with Dr. _____ ☐N/A
Post Exam Dialysis requested by Physician? ☐Yes ☐No
Follow up instructions given to patient if applicable? ☐Yes ☐No

Have you **ever** had an injection of MRI contrast (dye) before? ☐Yes – any problems?_____ ☐No

Have you **ever** had an injury from a metal object in your eye (metal slivers, metal shavings, other metal objects?)
☐Yes, explain_____ ☐No
If yes, did you seek medical attention? ☐ Yes ☐ No Were x-rays of your eyes done? ☐ Yes, where?_____ ☐No
MRI staff to fill out: Orbit report attached ☐Yes ☐ N/A ☐MRI since injury @ _____ year_____Orbits cleared by_____

Are you pregnant or do you suspect that you are pregnant? ☐Yes ☐No ☐Unsure LMP_____
Pregnancy Test Specific Gravity: _____ ☐Positive ☐Negative
Are you breast feeding? ☐ Yes ☐No

_____ (Initial)

The Welcome Back Centre believes in the advancement and improvement of medical care through research. The uniqueness of the multi-disciplinary team approach and the positional MRI is one of the means of analyzing and improving care. Your support is needed for this research.

I authorize the use of my obtained images and data to be used for research purposes maintaining my anonymity and confidentiality.

I attest that the above information is correct to the best of my knowledge.

Patient / Legal Guardian Signature_____ Date_____

Witness_____ Title of Witness_____
(Health Care Provider)

Translators:

I certify that I have read and translated all of the above information to the person who has signed this, and I am satisfied that I have correctly read and accurately translated the information.

Signature _____ Name (Please print) _____ Date (yyyy/mon/dd) _____

Gadolinium Injection

Lot #: _____
Expiry date: _____
Amount: _____
Time: _____
Covering Physician: Dr. _____
Tech Sign Off: _____
Print Name and Initial