Hôpital de Montréal pour enfants
Centre universitaire de santé McGill

Montreal Children's Hospital
McGill University Health Centre

QUESTIONNAIRE FOR AN MRI EXAMINATION

Exam requested: _____

Patient weight (kg): _____

For patient's safety:

NB TO DOCTORS: Please fill out the "PATIENT" column only

PLEASE ANSWER THE FOLLOWING QUESTIONS:	DOCTOR Patient		TECHNOLOGIST Parent or guardian	
	YES	NO	YES	NO
Is the patient pregnant?				
Does the patient have:				
1. Claustrophobia / vertigo?				
2. Neurosurgical devices? (includes shunt, valve, vagal nerve stimulator, Baclofen pump)				
3. Cardiac devices (includes prosthetic heart valve, pacemaker)				
4. Other electronic pacer implant (e.g. phrenic stimulator)				
5. Cochlear implant?				
6. Surgical aneurysm clip?				
7. Metal rods / plates? If yes, please check: ☐ Titanium ☐ Stainless steel				
8. Filter for clots (umbrella clamshell, other)?				
9. Metallic stent or any other metal fragments (including piercing or shrapnel)?				
10. Implanted insulin / chemotherapy pump?				
11. Dentures / braces / orthodontic appliance?				
12. Has the patient had previous surgery?				
If yes to any of the above, please specify:				
Will patient require sedation for the MRI? If yes, please complete section below:				
Does the patient have any of the following risk factors for sedation or contrast?				
1. Oxygen-dependent?				
2. Sleep apnea				
3. Noisy breathing / snoring / adenoids / tonsil problem?				
4. Anatomic airway abnormality?				
5. History of difficult intubation?				
6. Life-threatening underlying medical / surgical conditions?				
7. Non life-threatening but significant medical / surgical and conditions (e.g. syndrome)?				
8. Significant cardiac, pulmonary or CNS dysfunction?				
9. History of poor experience with conscious sedation?				
10. Physical or intellectual deficiencies? If yes, please check: ☐ Mild ☐ Moderate ☐ Severe				
11. Sedation considerations: is patient > 15 kg? (33 lbs)? ☐ Yes ☐ No				
If yes to any of the above, please specify:				
History of a major allergy or anaphylactic reaction? Please specify:				
History of renal problems? Please specify:				
If yes, provide recent creatinine and GFR:				

I was given information concerning the MRI examination. I have reviewed the above questionnaire with my physician, it is correct and I consent to the MRI examination.

Questionnaire reviewed with: Patient ☐ Parent ☐ Guardian ☐

Physician's name (please print)	Physician's signature & license number	Date YYYY / MM / DD
Patient's / guardian's / parent's name (please print)	Patient's / guardian's / parent's signature	Date YYYY / MM / DD
Radiology Technologist's name (please print)	Radiology Technologist's signature	Date YYYY / MM / DD
Radiology Nurse's signature	Radiology Nurse's name (please print)	Date YYYY / MM / DD

INCOMPLETE FORMS WILL BE RETURNED RESULTING IN A DELAY TO OBTAIN AN APPOINTMENT