



Personal Details

Name _____

Date of birth _____ Weight (kg) _____ Height (cm) _____

When is the next appointment with your doctor? _____

Fee Quote \$ _____ Date _____ Patient Signature _____

You cannot claim a Medicare rebate for your MRI scan due to restrictions on MRI licenses placed by the Government. The fee for MRI at Envision Medical Imaging is substantially discounted and is near the 'gap' fee of other premium MRI services in Perth. Private Health Funds do not currently cover the cost of MRI scans done anywhere in Australia.

The MRI scanner is a very strong magnet which can adversely affect certain metals or implanted devices. Please answer the following questions carefully to ensure your safety.

The MRI technologist will answer any queries prior to your scan.

Please circle your response and answer all questions on both sides of this page.

Have you had an MRI scan before? _____ YES NO

If YES, where? _____ Which body part? _____

Have you **EVER** had surgery on your heart? _____ YES NO

Do you have, or have you **EVER** had a Cardiac Pacemaker/Defibrillator? _____ YES NO

Have you **EVER** had surgery on your brain, ears or eyes? _____ YES NO

Do you have any Metallic Implants? eg. Aneurysm clip (brain), Stapedectomy (ears), Vascular stent (eg. AAA, coronary, renal), Metal clips, Screws, Rods, or Joints _____ YES NO

Do you have any Electronic Implants? eg. Cochlear implant, Neurostimulator, Pacing wires/electrodes, Morphine/Insulin pump _____ YES NO

Do you grind, weld, or cut metal? _____ YES NO

Have you **EVER** had a metallic foreign body in your eye? _____ YES NO

Do you wear a hearing aid? _____ YES NO

Do you have removable dentures/dental plates? _____ YES NO

Do you wear a wig or have hair extensions? _____ YES NO

Are you currently using any medicated skin patches? _____ YES NO

Are you pregnant or currently breastfeeding? _____ YES NO



MRI Patient Checklist

Please list any other metallic items you may have in or on your body that you think we should be aware of:

Briefly describe your symptoms:

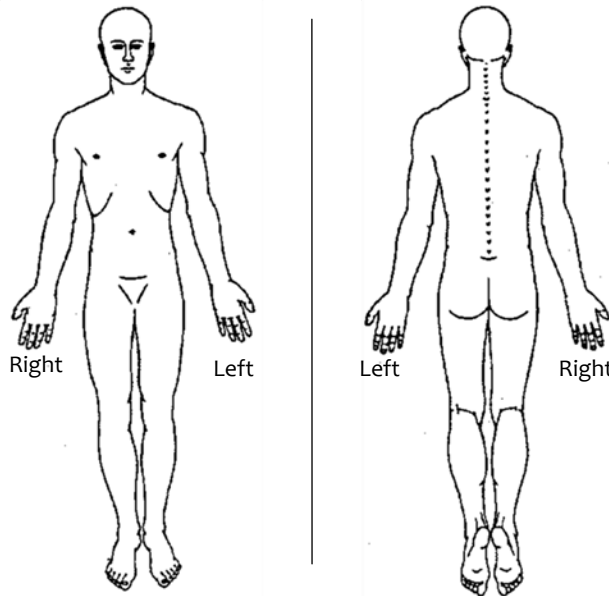
How long have you had these symptoms (*days / weeks / months*)?

Have you ever had an operation on the area of your body being scanned today? *If YES, please describe*

Have you had other treatment/injections related to the area being scanned today? *If YES, please describe*

Do you have any history of other major health problems? *If YES, please describe*

Please highlight the areas that are painful (*if relevant*) on the diagram below



Your signature _____ Date _____

MRI Tech (name) _____ Date _____

