SANDTON RADIOLOGY
Preventive & Diagnostic Imaging

PR NO. 3803945

Reg. No.1973/010447/07

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MRI CENTRE – MORNINGSIDE X-RAY DEPARTMENT

PATIENT NAME _____ DATE OF BIRTH _____

1. WHAT DO YOU WEIGH? _____
2. ARE YOU PREGNANT? Y / N
3. ALLERGIES? _____
4. CLAUSTROPHOBIC? Y / N
5. RELATED SURGERY? _____
6. PREVIOUS RELATED X-RAY/CT/MRI? _____

DO YOU HAVE ANYOF THE FOLLOWING ITEMS IN YOUR BODY?

PACEMAKER	Y	N	BRAIN CLIPS	Y	N
VENOUS UMBRELLA	Y	N	METAL FRAGMENTS	Y	N
BRACES / METALIC IMPLANTS	Y	N	NEUROSTIMULATOR	Y	N
VENTRICULAR / SPINAL SHUNT	Y	N	JOINT REPLACEMENTS	Y	N
AORTIC CLIPS	Y	N	ELECTRODES	Y	N
SHRAPNEL	Y	N	IUCD (LOOP)	Y	N
HEARING AID	Y	N	COCHLEAR IMPLANTS	Y	N
DENTURES	Y	N	HARRINGTON ROD	Y	N
HEART VALVE	Y	N	METAL MESH IMPLANT	Y	N

I hereby consent to the injection or administration of any drug or contrast media which may be necessary for the performance of my MRI examination.

PATIENT / GUARDIAN SIGNATURE _____ WITNESS _____ DATE _____