

MRI SAFETY CHECKLIST AND FINANCIAL CONSENT FORM



PATIENT DETAILS

Name: _____
Date of birth: _____
Weight: _____ Height: _____

YOUR APPOINTMENT is on:

Time: _____

Please arrive at: _____

FOR APPOINTMENTS AFTER MIDDAY: PLEASE RING **9508 1624 FOR MALVERN OR 9508 5665 FOR BRIGHTON** ON THE DAY OF YOUR APPOINTMENT TO CONFIRM YOUR ARRIVAL TIME. Please bring in any previous scans/x-rays and results.

Please indicate if you have (or have ever had) any of the following. Failure to do so, may lead to injury or death:

Head

Have you ever had?

- Aneurysm or AVM clips in the brain Yes No
- Brain or spinal shunt Yes No
- Eye injury involving metallic fragment Yes No
- Eye surgery involving implants (e.g. eyelid spring) Yes No
- Cochlear implant or middle ear surgery Yes No
- Any other head or brain surgery Yes No

Please describe: _____

Electronic or magnetic devices

Have you ever had?

- An insulin pump (Internal or external) Yes No
- Any other drug infusion pump Yes No
- Neurostimulator Yes No
- Penile implant Yes No
- Breast tissue expander Yes No
- Any other electronic or magnet devices Yes No

Please describe: _____

Heart

Have you ever had?

- Cardiac pacemaker, implanted defibrillator (ICD) or pacing wires Yes No
- Heart valve repair or replacement Yes No
- Cardiac loop recorder Yes No
- Any other heart surgery or implant Yes No

Please describe: _____

Coils, stents and filters

Have you ever had?

- Embolisation coils Yes No
- Inferior Vena Cava (IVC) filter Yes No
- Stents Yes No
- Any other surgery to your blood vessels Yes No

Please describe: _____

Gastrointestinal

Have you ever had?

- Pillcam capsule Yes No
- Metal clips in stomach/oesphagus/bowel from endoscopy (gastroscopy or colonoscopy) Yes No
- Any other bowel or stomach surgery or implant Yes No

Please describe: _____

Other

Have you ever had?

- Bullet, shrapnel or metallic foreign body Yes No
- Spinal surgery including Harrington rods Yes No
- An IUD Yes No
- Any operation in the last six weeks Yes No

Please describe: _____

To avoid any inconvenience please contact the MRI department on 9508 1614 (Malvern) and 9508 5665 (Brighton) if you have answered YES to any of the above questions. More information may be required before it is safe to proceed with your MRI examination.

MRI SAFETY CHECKLIST AND FINANCIAL CONSENT FORM

For your safety, please indicate if you have any of the following:

- Bone/joint pin, screw, nail, wire, etc. Yes No
- Wig, toupee, hair extensions Yes No
- Denture or partial plate Yes No
- Joint replacement or prosthetic limb Yes No
- Are you claustrophobic? Yes No
- Medication patch Yes No
- Hearing aid Yes No
- Tattoos/permanent or magnetic makeup Yes No
- Body piercing jewelry Yes No

Are you pregnant or breastfeeding? Yes No

Have you had an MRI before? Yes No

Which hospital/clinic(s) and date(s):

MRI FEES EXPLAINED

Private patients: MRI Procedures will incur a \$250 patient out-of-pocket cost per visit for Medicare funded items (both GP and Specialist items). Not all MRI examinations attract a Medicare Rebate, most of these scans will incur a \$365 out-of-pocket cost per body area. If contrast is required, there is an additional \$100 patient out-of-pocket cost. Some non-rebatable MRI scans, including those of the abdomen or breast, will attract an out-of-pocket fee of up to \$630. Please call 9508 1614 (Malvern) or 9508 5665 (Brighton) for the cost.

Please note: Cabrini Medical Imaging does not Bulk Bill MRI procedures for private patients where a request has been made to do so by the referring GP or Specialist.

Pensioners and Concession Cardholders: The majority of MRI scans attract a Medicare Rebate. Examinations that have a Medicare item number will be bulk billed.

Third Party Claims: DVA/WorkCover/TAC will be billed to the relevant authority. However, should the claim be rejected, it is the patient's responsibility to settle all outstanding accounts. An account will be sent to the patient for payment. Please bring in relevant cards or claim numbers and insurer details to your appointment.

Overseas Insurance: is not accepted at Cabrini Health. As such, it is the patients' responsibility to settle all outstanding accounts. An account and receipt will be provided.

Sedation: If you require sedation, there will be an additional cost of **\$250**.

A fee of **\$100** will be charged if less than 24-hours notice of cancellation is given.

PATIENT ID PROCEDURE MATCH (Office use only)

<input type="checkbox"/> Name	<input type="checkbox"/> DOB	<input type="checkbox"/> Correct procedure
<input type="checkbox"/> Address	<input type="checkbox"/> UR Number	<input type="checkbox"/> Correct side
<input type="checkbox"/> Verbal consent	Radiographer: _____	



BEFORE entering the MRI scan room, **all metallic objects/valuables must be removed and stored in the locker provided. All patients will be required to change into a hospital gown for their procedure.** Please consult the MRI technologist with any questions or concerns **BEFORE** you enter the MRI scan room.

WARNING: MRI does not use x-rays but uses a large magnet to image the body. The magnet is always on and your entire body will be exposed to the magnetic field. For every MRI visit, the above questionnaire must be fully completed and will be double checked by the MRI radiographer on-duty prior to your MRI examination. If you have any questions, please call the MRI department on 9508 1614 (Malvern) or 9508 5665 (Brighton) to talk to one of our trained staff.

I have read and understood all of these questions

I, _____ acknowledge that to the best of my understanding, the above answers are true and I have read the above information and acknowledge that I understand my responsibility concerning payment of out-of-pocket expenses for my MRI scan.

Patient Guardian

Signature _____

Date _____