

## MeRT SAFETY CHECKLIST



19 – 31 Dickson Road, Morayfield QLD 4506  
www.braintreatmentcentre.com.au

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

This form must be completed and signed by the client.

Please complete the following questions by checking Yes or No. If you have any questions, please ask the staff.

<b>Have you ever had:</b>	<b>Yes</b>	<b>No</b>	<b>Not Sure</b>
Heart surgery			
Brain surgery			
Ear surgery			
Have you ever been a metal worker?			
<b>Do you have (or have you ever had) any of the following?</b>	<b>Yes</b>	<b>No</b>	<b>Not Sure</b>
Seizure			
History of a primary brain cancer or metastasis to brain?			
Pacemaker/pacing wires			
Internal cardiac defibrillator (ICD)			
Brain aneurysm clip			
Cochlear Implant			
Artificial heart valve			
Neurostimulator/Biostimulator			
IVC filter			
Any type of intravascular coils, filters or stents			
Swanz-Ganz catheter			
Vascular clips or wires			
Brain shunt			
Metal pin, plates, rods, screws, prostheses			
Ocular (eye) prosthesis			
Stapes (ear) implant			
Hearing Aid			
Shrapnel or bullet wounds			
Any type of body piercing			
Do you have an implanted pain relief pump?			
Have you had any operations in the last (6) weeks?			
Bipolar disorder I?			
Pregnant?			
Breastfeeding?			
Tattoos – Metallic or magnetic sensitive ink			
<b>Do you understand all of these questions?</b>			

**I acknowledge that to the best of my understanding, the above answers are true and I consent to the MeRT treatment.**

Signature of client or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Clinician: \_\_\_\_\_

Date: \_\_\_\_\_