MRI Patient Screening Form - Part A

MRI SERVICES PATIENT INFORMATION

Date of Exam: _____ Exam Ordered: _____

Patient Name: _____ Physician/Specialty: _____

Date of Birth: _____ Diagnosis: _____

Patient Stated Weight: _____ Medical Record #: _____

Facility Name: _____ Patient's Zip Code: _____

Reason for Exam: _____

PATIENT HISTORY

MRI CANNOT be performed **if "Yes"** is answered to triple asterisked (***) questions.
Double asterisked (**) require a signed contraindication release. Single asterisked (*) must be referred to radiologist.

*** Pacemaker or Pacemaker wires	❑ Yes	❑ No
*** Small Bowel Endoscopy Capsule	❑ Yes	❑ No
*** Implanted Neurostimulators	❑ Yes	❑ No
*** Implanted Cardiac Defibrillator	❑ Yes	❑ No
** Pregnant / Breast Feeding	❑ Yes	❑ No
* Aneurysm Clips (Verify and document safety or refer to the radiologist)	❑ Yes	❑ No
* Carotid Clips	❑ Yes	❑ No
* Artificial Heart Valves	❑ Yes	❑ No
* Heart Stents	❑ Yes	❑ No

If yes to previous two questions need -

Date: _____ Make: _____

Model: _____

* History of severe hepatic disease/liver transplant/pending liver transplant (no contrast for perioperative liver pts.)	❑ Yes	❑ No
* Hypertension	❑ Yes	❑ No
* Vascular Clips/Grafts/Stents/Repair	❑ Yes	❑ No
* Surgical Clips	❑ Yes	❑ No
* Infusion Pump	❑ Yes	❑ No
* Programmable Shunt	❑ Yes	❑ No
* Allergies to IV dye, seafood, shellfish	❑ Yes	❑ No
* Dialysis/Renal Failure/Renal Insufficiency	❑ Yes	❑ No
* Iron deficiency or Anemia treated with Feraheme	❑ Yes	❑ No
* Metallic Foreign Body (Gun shot wounds, metal shavings in eye, retinal buckle, etc.)	❑ Yes	❑ No
* Prior Ear or Brain Surgery	❑ Yes	❑ No

Please list previous surgeries : _____

_____

_____

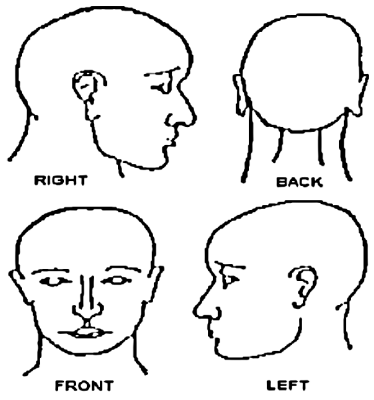
* Diabetes	❑ Yes	❑ No
* Diabetic Pump	❑ Yes	❑ No
* Wound Dressing (i.e. Acticoat 7)	❑ Yes	❑ No
* Breast Tissue Expanders	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Irregular Heartbeat	❑ Yes	❑ No
External Electrodes/Neurostimulators (Tens-unit)	❑ Yes	❑ No
Vena Cava Umbrella Filter	❑ Yes	❑ No
Latex Allergies	❑ Yes	❑ No
History of Cancer	❑ Yes	❑ No
Metallic Implant/Prosthesis/Orthopedic Devices	❑ Yes	❑ No
Removable Hearing Aid	❑ Yes	❑ No
Epilepsy (Seizures)	❑ Yes	❑ No
Uncooperative or Disoriented	❑ Yes	❑ No
Claustrophobia	❑ Yes	❑ No
Unable to Hold Still	❑ Yes	❑ No
Braces	❑ Yes	❑ No
Removable Dental Work	❑ Yes	❑ No
Glitter/Permanent Eye Makeup	❑ Yes	❑ No
Tattoos and/or Body Piercing	❑ Yes	❑ No
Medication Skin Patches	❑ Yes	❑ No

(Nitroglycerine, stop smoking, pain, birth control, etc.)

Any history with a * or ** must be approved by radiologist/supervising physician

Approved by: _____

Date: _____ **Time:** _____



Check Box below if a <u>previous</u> scan completed was similar to body part being examined today

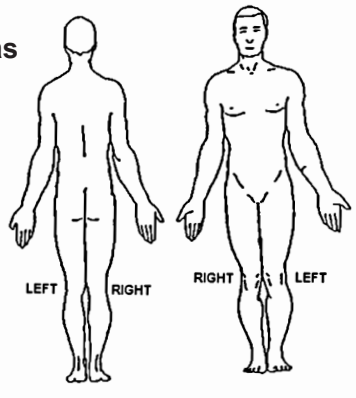
Previous MRI	❑ Yes	❑ No
Previous CT	❑ Yes	❑ No
Previous PET/PETCT	❑ Yes	❑ No
Previous X-Rays	❑ Yes	❑ No

If yes Specify Area

_____

_____

Using the figures, please shade in the areas affected by pain and/or numbness.



Signature of Patient: _____ **Date:** _____

(Parent or Guardian if patient is a Minor or Incapacitated)

I have reviewed this information with the patient or their legal guardian, power of attorney, next of kin, etc.

Tech's Signature: _____ **Date:** _____

MRI Patient Screening Form - Part B

Patient Name:_____ **Date of Birth:**_____ **Date:**_____

CONTRAST

Your physician or radiologist may deem it necessary for you to have an IV injection of a contrast agent containing gadolinium to improve the quality of your MR examination. Although gadolinium contrast agents have been used safely in millions of patients, minor reactions (principally headache or nausea), and serious or life threatening reactions may occur.

I have read and understand the above information, and have had my questions answered. I agree to have the MRI procedure with injection of contrast if deemed necessary.

History of previous reaction ❑ Yes ❑ No

If Yes, Explain _____

Patient Stated Weight _____

eGFR _____ (Range: Low = 30 High = > 60)

_____Date: _____

Signature of Patient (Parent or Guardian if patient is a Minor or Incapacitated)

Contrast Name _____

Amount _____

Lot #_____

Exp. Date_____

Injection Site _____

Device Used _____

Rate of Admin._____

Tech Initials _____

Post Injection Check: Time:_____ Has patient's condition changed since injection? No _____ Yes _____

If Yes, specify change: _____

Are you allergic to any medications, seafood, or shellfish?

❑ Yes ❑ No If Yes, please list:

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

❑ Patient unaware of current medications

❑ Patient not on any medications

Barriers to Learning ❑ Yes ❑ No

Type:	Intervention:
❑ Language	❑ Interpreter Used
❑ Hearing	❑ Repeat Questions
❑ Other	❑ Family/Significant Other

List any medication(s) the patient has taken today and all current medications:

(Include over the counter, ointments, herbals, vitamins, birth control, etc.)

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

Prior to release, patient was assessed and found impaired? ❑ Yes ❑ No If yes, Supervising Physician notified? ❑ Yes ❑ No

If patient refuses further assessment, notify Supervising Physician and Alliance personnel to follow policy #5023.

Comments:_____

MINOR MODIFICATIONS BY RADIOLOGIST/PHYSICIAN ❑ Yes ❑ No

Original Exam Order Changed to:_____ **Changed by:**_____ **Date/Time:** _____

Tech Signature: _____ **Read Back ❑ Yes ❑ No Physician Signature:** _____

Post Injection Instructions given (applicable to all patients who receive an injection).	**❑ Yes**	**❑ No**
Patient notified of rights and opportunity to "Speak up" with questions or concerns.	**❑ Yes**	**❑ No**
Handoff Report given to next provider of care. Medication list provided if applicable.	**❑ Yes**	**❑ No**

Interviewer Signature _____

Title: _____ **Date:** _____

Tech Comments_____

_____

_____