MRI Patient Screening Form - Part A

MRI SERVICES PATIENT INFORMATION

Patient Name: _____ Date of Exam: _____

Date of Birth: _____ Exam Ordered: _____

Medical Record #: _____ Diagnosis: _____

Patient Stated Weight: _____ Pt. Address: _____

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 informed consent. Single asterisked (*) must be referred to radiologist for approval.

***	**Pacemaker or Pacemaker wires** (past or present)	❑ Yes	❑ No
***	**Small Bowel Endoscopy Capsule**	❑ Yes	❑ No
***	**Implanted Neurostimulators**	❑ Yes	❑ No
***	**Implanted Cardiac Defibrillator** (past or present)	❑ Yes	❑ No
***	**LVAD Device (Heart Pump)**	❑ 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** (High Blood Pressure)	❑ 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
*	**Diabetes**	❑ Yes	❑ No
*	**Diabetic Pump**	❑ Yes	❑ No
*	**Wound Dressing (i.e. Acticoat 7)**	❑ Yes	❑ No
*	**Breast Tissue Expanders**	❑ Yes	❑ No

History of Falls	❑ Yes	❑ No
If yes, most recent fall date _____		
Asthma	❑ Yes	❑ No
Irregular Heartbeat	❑ Yes	❑ No
External Electrodes/Neurostimulators (Tens-unit)	❑ Yes	❑ No
Vena Cava Umbrella Filter	❑ Yes	❑ No
Endoscopy/Colonoscopy in past 2 years? (Possible GI Clips may require x-rays)	❑ Yes	❑ No
Latex Allergies	❑ Yes	❑ No
History of Cancer (Patient)	❑ Yes	❑ No
History of Breast Cancer	❑ Yes	❑ No
If yes, any lymph nodes removed?	❑ 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
Pins in Hair or Clothes	❑ Yes	❑ No
Hair Extensions/Hair Pieces/Wig	❑ 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 (Nitroglycerine, stop smoking, pain, birth control, etc.)	❑ Yes	❑ No

Colored contacts must be removed.

Please list previous surgeries : _____

_____

_____

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 PET/PET/CT ❑ Yes ❑ No

Previous CT ❑ Yes ❑ No Previous X-Rays ❑ Yes ❑ No

If yes Specify Area

_____

_____

Factors such as weight, body habitus and scan type may determine if scan can be performed.

Signature of Patient: _____ **Date:** _____
(Parent or Guardian if patient is a Minor or Incapacitated)

Interviewer's Signature: _____ **Date:** _____

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 _____

If patient has self-medicated for anxiety/claustrophobia specifically for today's procedure (not routine medications), do they have a driver? ❑ Yes ❑ No

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**	**❑ N/A**
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**	**❑ N/A**
Patient received ear protection.	**❑ Yes**	**❑ No**	

Team Member Signature_____

Title: _____ **Date:** _____

Tech Comments_____

_____

_____