

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: _____
 Emergency Contact Name: _____ Phone Number: _____ (Cell # if Avail.) _____

PATIENT HISTORY

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

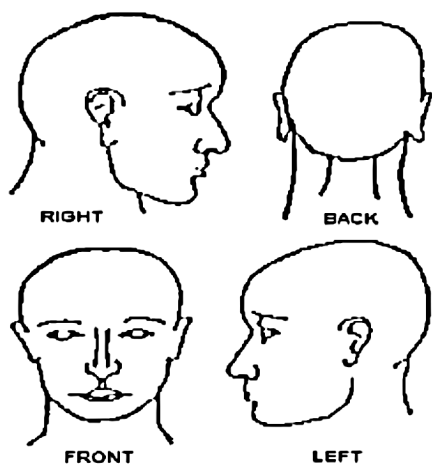
- | | |
|--|--|
| *** Pacemaker or Pacemaker wires <input type="checkbox"/> Yes <input type="checkbox"/> No
*** Small Bowel Endoscopy Capsule <input type="checkbox"/> Yes <input type="checkbox"/> No
* Carotid Clips <input type="checkbox"/> Yes <input type="checkbox"/> No
* Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No
* Heart Stents <input type="checkbox"/> Yes <input type="checkbox"/> No | ** Pregnant / Breast Feeding <input type="checkbox"/> Yes <input type="checkbox"/> No
* Metallic Foreign Body <input type="checkbox"/> Yes <input type="checkbox"/> No
(Gun shot wounds, metal shavings in eye, retinal buckle, etc.)
* Prior Ear or Brain Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

If yes to previous two questions need - Date: _____ Make: _____ Model: _____

- | | |
|---|--|
| * Aneurysm/Vascular Clips/Grafts/Stents/Repair <input type="checkbox"/> Yes <input type="checkbox"/> No
* Surgical Clips <input type="checkbox"/> Yes <input type="checkbox"/> No
* Infusion Pump <input type="checkbox"/> Yes <input type="checkbox"/> No
* Allergies to IV dye, seafood, shellfish <input type="checkbox"/> Yes <input type="checkbox"/> No
* Dialysis/Renal Failure/Renal Insufficiency <input type="checkbox"/> Yes <input type="checkbox"/> No
Latex Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No
History of Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No
Metallic Implant/Prosthesis Orthopedic Devices <input type="checkbox"/> Yes <input type="checkbox"/> No
Wound Dressing (i.e. Acticoat 7) <input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No
Electrodes/Neurostimulators (Tens-unit) <input type="checkbox"/> Yes <input type="checkbox"/> No
Vena Cava Umbrella Filter <input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Tissue Expanders <input type="checkbox"/> Yes <input type="checkbox"/> No | Removable Hearing Aid <input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy (Seizures) <input type="checkbox"/> Yes <input type="checkbox"/> No
Uncooperative or Disoriented <input type="checkbox"/> Yes <input type="checkbox"/> No
Claustrophobia <input type="checkbox"/> Yes <input type="checkbox"/> No
Unable to Hold Still <input type="checkbox"/> Yes <input type="checkbox"/> No
Braces <input type="checkbox"/> Yes <input type="checkbox"/> No
Removable Dental Work <input type="checkbox"/> Yes <input type="checkbox"/> No
Glitter Eye Makeup <input type="checkbox"/> Yes <input type="checkbox"/> No
Tattoos and/or Body Piercing <input type="checkbox"/> Yes <input type="checkbox"/> No
Medication Skin Patches <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

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

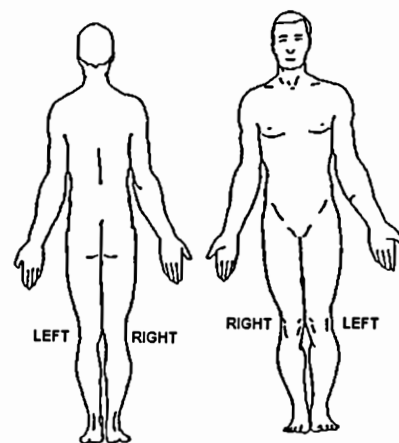
Orbits/X-ray/Any history with a * or ** approved by radiologist/nephrologist Yes No If no, explain: _____



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

- Previous MRI Yes
 Previous CT Yes
 Previous PET/PETCT Yes
 Previous X-Rays Yes

If yes Specify Area



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

Patient Signature: _____ Date: _____

Reason for Exam: _____

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 and injection of contrast if deemed necessary.

History of previous reaction Yes No

If Yes, Explain _____

Patient Stated Weight _____

Name of Contrast _____ Lot _____

Amount _____ Exp. Date _____

Injection Site: _____

Injected By: _____

Date: _____

Signature of Patient (Parent or Guardian)

Tech Comments: _____

Pain Screening for Verbal Patients

Is the patient having pain **before** the exam?

Yes No Interventions _____

Is the patient experiencing discomfort **during** the exam?

Yes No Interventions _____

Was the patient's pain and/or discomfort increased

after the exam? Yes No

If yes, instruct patient to contact their physician.

Pain Screening for Non-Verbal Patients

Does the patient have facial expressions or activities that would indicate the patient is having pain **before** the exam?

Yes No Interventions _____

Is the patient experiencing discomfort **during** the exam?

Yes No Interventions _____

Was the patient's pain and/or discomfort increased **after**

the exam? Yes No

If yes, notify a member of the Health Care Team.

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

Yes No If Yes, please list:

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

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

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

Patient unaware of current medications

Patient not on any medications

Intervention Method Used:

- A. Cushion(s)
- B. Pillow(s)
- C. Talked pt. through exam
- D. Blanket
- E. Modified exam time
- F. Consulted radiologist
- G. Other

Barriers to Learning

Yes No

Type:

Intervention:

Language

Interpreter Used

Hearing

Repeat Questions

Other

Family/Significant Other

Prior to release, patient was assessed and found impaired? Yes If yes, Supervising Physician notified? Yes No
If patient refuses further assessment, notify Supervising Physician and Alliance personnel to follow policy #5023.

MINOR MODIFICATIONS BY RADIOLOGIST/PHYSICIAN

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

Tech Signature: _____ Read Back Physician Signature: _____

Post Injection Instructions given (applicable to all patients who receive an injection).

Handoff Report given to next provider of care. Medication list provided if applicable.

Interviewer (Print) _____