MRI Patient Screening Form - Part A

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

Last Name _____

First Name _____

Date of Birth _____ **Date** _____

Height: _____ Weight: _____ lbs./kg.

Patient Address: _____

City, State, Zip: _____

Patient: Please complete all the information contained in this boxed section.

Any Medical/Dental Procedures requiring sedation in the past 24 hours? ☐ Yes ☐ No

*** **Small Bowel Endoscopy Capsule** ☐ Yes ☐ No

*** **Implanted Cardiac Defibrillator** (past or present) ☐ Yes ☐ No

*** **LVAD Device (Heart Pump)** ☐ Yes ☐ No

*** **Breast Tissue Expanders** ☐ Yes ☐ No

** **Pacemaker or Pacemaker wires** (past or present) ☐ Yes ☐ No

** **Implanted Neurostimulator** ☐ Yes ☐ No

** **Pregnant** ☐ Yes ☐ No

* **Artificial Heart Valves/Heart Stents** ☐ Yes ☐ No

Date: _____ Make: _____

Model: _____

* **Surgical Clips/Vascular Clips/Grafts/Stents/Repair** ☐ Yes ☐ No

Type: _____

* **Medication Pump** ☐ Yes ☐ No

* **External Tens Unit** ☐ Yes ☐ No

* **Aneurysm Clips** ☐ Yes ☐ No

* **Recent colonoscopy or digestive system procedure involving surgical clips** ☐ Yes ☐ No

* **Metallic Foreign Body** (Gun shot wounds, retinal buckle, etc.) ☐ Yes ☐ No

* **Eye injury involving Metal** ☐ Yes ☐ No

* **Prior Ear, Eye or Brain Surgery** ☐ Yes ☐ No

Joint Replacement/Implants ☐ Yes ☐ No

Orthopedic or Prosthesis Devices ☐ Yes ☐ No

Vena Cava Umbrella Filter ☐ Yes ☐ No

Pins in Hair or Clothes ☐ Yes ☐ No

Hair Extensions/Hair Pieces/Wig ☐ Yes ☐ No

Braces or Oral Springs ☐ Yes ☐ No

Removable Dental Work ☐ Yes ☐ No

Glitter/Permanent Eye Makeup ☐ Yes ☐ No

Tatoos and/or Body Piercing ☐ Yes ☐ No

Removable Hearing Aid ☐ Yes ☐ No

Clothing with Metallic or Anti-Microbial Fibers? ☐ Yes ☐ No

Medication Skin Patches ☐ Yes ☐ No

History of Cancer ☐ Yes ☐ No

If yes, what type? _____

Anything in your body that you weren't born with? ☐ Yes ☐ No

If not listed above, notify the Technologist.

Please list previous surgeries not already mentioned and their dates:

_____

_____

_____

_____

I have answered the above questions accurately. I understand that I must remove all metallic items including my cell phone prior to entering the MRI scan room and a secure area will be provided for my personal belongings. Failure to remove such items can result in serious damage to those items and/or injury to me and others.

Patient Initials _____

Any previous imaging study related to the reason for today's exam? ☐ Yes ☐ No

Type of Exam _____

Facility _____

Date _____

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

(Parent or Guardian if patient is a Minor or Incapacitated) **Relationship:** _____

MRI CANNOT be performed if **"Yes"** is answered to triple asterisked (***) questions. Double asterisked (**) require a signed informed consent. Single asterisked (*) may require further discussion between radiologist & technologist. Document any verbal approvals on Part B.

Medical Record # / Accession #: _____ Facility Name: _____

Exam Ordered - MRI of: _____ Referring Physician/Specialty: _____

Diagnosis: _____

Clinical Pause #1 Conducted ..... ☐ **Yes** ☐ **No**

Reason for Exam/Clinical Symptoms: _____

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

Technologist Comments _____

Technologist's Signature: _____ **Date:** _____

MRI Patient Screening Form - Part B

Patient's preferred language for discussing healthcare

☐ English ☐ Spanish ☐ Other _____

Last Name _____

First Name _____

Date of Birth _____ **Date** _____

Claustrophobic? ..... ☐ Yes ☐ No

Did patient pre-medicate for this exam? ..... ☐ Yes ☐ No

If yes, does patient have a driver? ..... ☐ Yes ☐ No

Iron Deficiency being treated with Feraheme ..... ☐ Yes ☐ No

Diabetic? ..... ☐ Yes ☐ No

History of Epilepsy (seizures)? ..... ☐ Yes ☐ No

Chronic Heart Disease (CHF)? ..... ☐ Yes ☐ No

Currently Breast Feeding? ..... ☐ Yes ☐ No

Asthma? ..... ☐ Yes ☐ No

History of Diarrhea in past 2-3 days? ..... ☐ Yes ☐ No

History of Falls within past 30 days? ..... ☐ Yes ☐ No

If Yes, when _____

Allergies to any medications? ..... ☐ Yes ☐ No

Please List: _____

_____

Allergies to any seafood or shellfish? ..... ☐ Yes ☐ No

Allergy to Latex? ..... ☐ Yes ☐ No

List any medications taken today and all current medications. Include all prescriptions, over the counter items, ointments, vitamins, and herbals. Attach list if available.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Did the patient receive an IV injection? ☐ Yes ☐ No

If yes, attachment A054 must be completed and signed.

Barriers to Learning ☐ Yes ☐ No

Type:

☐ Language

☐ Hearing

☐ Other _____

Interventions:

☐ Interpreter Used

☐ Repeat Questions

☐ Family/Significant Other

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.

Injection site evaluated? ☐ Yes ☐ No ☐ N/A Note appearance: _____

Comments: _____

RECEIPT OF VERBAL ORDERS, TEST RESULTS, MODIFICATIONS, OR OTHER INSTRUCTIONS ☐ Yes ☐ No

Information Received: _____

Readback confirmed with _____ Title _____ Date _____ Time _____

Technologist or Radiologist Signature _____ Date _____ Time _____

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

If retail, Patient Rights & Responsibilities provided to the patient. ..... ☐ Yes ☐ No ☐ N/A

Patient received ear protection. ..... ☐ Yes ☐ No

Are patient reminder calls for this site made by Alliance Team Members? ..... ☐ Yes ☐ No ☐ EMR

If yes to above and NOT documented in an EMR or Intergy, complete row below.

Team Member Name: _____ Date: _____ Time: _____

Summary: _____

Clinical Pause #2 conducted prior to image transfer? ☐ Yes ☐ No Tech Initials _____

Team Member Signature and Title: _____

PATIENT SIGNATURE BELOW ONLY AT THE COMPLETION OF EXAM.

I did not leave any personal belongings upon completion of exam. _____