# MRI - Part A

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

Height: _____ Weight: _____ lbs./kg.

**Last Name** _____

**First Name** _____

**Date of Birth** _____ **Date** _____

**Patient safety is our primary concern. The MRI room contains a very strong magnet and is ALWAYS on. Before you are allowed to enter the MRI room, we must know if you have any metal in or on your body. You MUST remove all metallic objects including cell phone, keys, watches, hair pins, pocket knives, lighters, bank cards, purses, wallets, jewelry, etc. Hearing aids must be removed immediately before entering the MRI room. Failure to remove such items can result in serious damage to those items and/or injury to yourself and others. Please answer the following questions carefully.**

**I have read and understand the above information, and have removed all metal.....☐ Yes ☐ No**

**Medical/Dental Procedures with sedation in the past 24 hours?.....☐ Yes ☐ No**

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

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

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

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

****Existing Pacemaker or Pacemaker wires ☐ Yes ☐ No**

****Pregnant.....☐ Yes ☐ No**
**Last Menstrual Period** _____

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

***Artificial Heart Valves/Heart Stents.....☐ Yes ☐ No**
Date: _____ Make: _____
Model: _____

***Surgical/Vascular Clips/Grafts/Stents..... ☐ Yes ☐ No**
Type: _____

***Aneurysm Clips.....☐ Yes ☐ No**

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

***Medication Pump.....☐ Yes ☐ No**

***External TENS Unit.....☐ 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**

***Catheter, Drainage Tube, Temp Monitor.....☐ Yes ☐ No**

**Hearing Aids.....☐ Yes ☐ No**

**Dri Weave, Dri Fit or Wicking Clothing.....☐ Yes ☐ No**

**Medication Skin Patches.....☐ Yes ☐ No**

**History of Cancer.....☐ Yes ☐ No**
**If yes, what type?** _____

**Joint Replacement/Joint Implants.....☐ Yes ☐ No**

**Orthopedic or Prosthetic Devices.....☐ Yes ☐ No**

**Vena Cava Umbrella Filter.....☐ Yes ☐ No**

**Hair Extensions/Hair Pieces/Wig.....☐ Yes ☐ No**

**Braces, Oral Springs, Removable Dental Work.....☐ Yes ☐ No**

**Glitter/Permanent Eye Makeup.....☐ Yes ☐ No**

**Anything Held with Magnets or Pins.....☐ Yes ☐ No**

**Tattoos and/or Body Piercing.....☐ Yes ☐ No**

**Claustrophobic?.....☐ Yes ☐ No**

**Iron Deficiency being treated w/ Feraheme ☐ Yes ☐ No**

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

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

**Any falls within past 30 days?.....☐ Yes ☐ No**
If yes, when: _____

**Anything in or on your body that you weren't born with?**
**☐ Yes ☐ No If not listed above, notify the Technologist.**

**Did you pre-medicate for this exam?.....☐ Yes ☐ No**
**Do you have a driver?.....☐ N/A ☐ Yes ☐ No**

**Please list all past surgeries and their dates:**

_____

_____

**Any previous imaging study related to the reason for today's exam?.....☐ Yes ☐ No**
**Type of Exam** _____
**Facility** _____
**Date** _____

**I have answered the questions above accurately.**

**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 the Radiologist & Technologist. Document any verbal approvals/instructions on Part B.

***I have reviewed each response with the patient or their legal guardian, power of attorney, next of kin, etc. and PERFORMED CLINICAL PAUSE #1.***

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

# MRI - Part B

Medical Record # / Accession #: _____
Referring Physician: _____
Exam Ordered - MRI of: _____
Diagnosis: _____
Facility Name: _____

**Last Name** _____
**First Name** _____
**Date of Birth** _____ **Date** _____

Reason for Exam/Clinical Symptoms: _____

**Clinical Pause #1:** Correct Patient ☐ Correct Procedure ☐ Correct Body Part ☐
Lowest SAR Utilized ☐ Correct Positioning ☐ Tech Initials _____

Site staff accompanying patient received:
- MRI Safety training? ..... ☐ Yes ☐ No ☐ N/A
- Written safety screening per policy ..... ☐ Yes ☐ No ☐ N/A

Patient's preferred language for discussing healthcare: ☐ English ☐ Spanish ☐ Other _____
Allergies to any medications, food or latex? ..... ☐ Yes ☐ No Please List: _____
List all current medications including all prescriptions, over the counter items, ointments, vitamins, and herbals. Attach list if available.

Check the box for any medications taken today.

_____ ☐ _____ ☐ _____ ☐ _____ ☐
_____ ☐ _____ ☐ _____ ☐ _____ ☐

☐ Patient unaware of current medications ☐ Patient not on any medications ☐ Medication list attached (includes name & DOB)

Will the patient receive an IV injection? ☐ Yes ☐ No
If yes, attachment A054 must be completed and signed.
**Injection site evaluated? ☐ Yes ☐ No ☐ N/A Note appearance:** _____
Post Injection Instructions given
(applicable to all patients who receive an injection). ..... ☐ Yes ☐ No ☐ N/A

**Barriers to Learning** ☐ Yes ☐ No

| **Type:** | **Interventions:** |
|---|---|
| ☐ Language | ☐ Interpreter ID#_____ |
| ☐ Hearing | ☐ Repeat Questions |
| ☐ Other _____ | ☐ Family/Significant Other |

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

Information Received: _____
Readback confirmed with _____ Title _____ Date _____ Time _____
Technologist Signature _____ Date _____ Time _____
Radiologist Signature _____ Date _____ Time _____

Patient was encouraged to "Speak Up" with questions or concerns. ..... ☐ Yes ☐ No
If retail, Patient Rights & Responsibilities provided to the patient. ..... ☐ Yes ☐ No ☐ N/A
Patient received ear protection. ☐ Yes ☐ No If no, explain _____

**Clinical Pause #2** conducted prior to image transfer (Correct labeling, annotation and image quality)? ☐ Yes ☐ No Tech Initials _____

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 team member to follow policy #5023.

Tech Comments: _____

Team Member Signature and Title: _____

***PATIENT SIGNATURE BELOW ONLY AT THE COMPLETION OF EXAM.***

**I retrieved all of my personal belongings upon completion of exam.** ❑ Yes ❑ No ❑ N/A
**I give my consent to receive communication/survey via text or e-mail.** ❑ Yes ❑ No ❑ N/A
*(Data rates may apply depending on your mobile carrier.)*
**Preferred Method of Communication:** ❑ Cell ❑ E-mail
**Cell #:** (____) _____ **E-mail:** _____
**I have received a copy of the terms and conditions for electronic communication.**
❑ Yes ❑ No ❑ N/A **Patient Signature** _____