MRI Patient Screening Form - Part A

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

Patient Label or Accession Number

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

Patient Name (Last, First):_____ Date of Birth: _____

Patient Address: _____ Date of Exam: _____

City, State, Zip: _____ Patient Stated Weight: _____lbs/kgs Height:_____

Please list previous surgeries and their dates: _____

_____

***	**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
*	**Aneurysm Clips**	❑ Yes	❑ No
*	**Recent colonoscopy or digestive system procedure involving surgical clips (Possible GI Clips may require x-rays)**	❑ Yes	❑ No
*	**Surgical Clips/Vascular Clips/Grafts/Stents/Repair**	❑ Yes	❑ No
	Type:_____		
*	**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 or Brain Surgery**	❑ Yes	❑ No
*	**Receiving treatment for gout?**	❑ Yes	❑ No
*	**Artificial Heart Valves/Heart Stents**	❑ Yes	❑ No

If yes:

Date: _____ **Make:** _____

Model: _____

I have answered the above questions accurately. I understand that I must remove all metallic items 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 damage to those items and/or injury to me and others.

Patient Initials _____

Are you breastfeeding?	❑ Yes	❑ No
History of Falls within past 30 days	❑ Yes	❑ No
If yes, most recent fall date _____		
Asthma or Chronic Heart Disease, CHF	❑ Yes	❑ No
Vena Cava Umbrella Filter	❑ Yes	❑ No
History of Cancer	❑ Yes	❑ No
If yes, what type? _____		
Joint Replacements/Implants	❑ Yes	❑ No
Orthopedic or Prosthesis Devices	❑ Yes	❑ No
Epilepsy (Seizures)	❑ Yes	❑ No
Claustrophobia	❑ 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
Tattoos and/or Body Piercing	❑ Yes	❑ No
Removable Hearing Aid	❑ Yes	❑ No
Medication Skin Patches	❑ Yes	❑ No
History of Diarrhea in past 2-3 days	❑ Yes	❑ No
Iron deficiency treated w/Feraheme	❑ Yes	❑ No
Personal history of diabetes	❑ Yes	❑ No

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 Physican/Specialty: _____

Diagnosis: _____

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

MRI Patient Screening Form - Part B

Patient Label or Accession Number

Patient Name (Last, First): _____

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

Did the patient receive an IV injection? ❑ Yes ❑ No If yes, attachment A054 must be completed and signed.

Clinical pauses conducted prior to exam **AND** prior to image transfer.

Tech Initials ____

Patient's preferred language for discussing healthcare:

❑ English ❑ Spanish ❑ Other _____

Is the patient allergic to any medications, seafood, shellfish, or latex?

❑ Yes ❑ No If Yes, please list:

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

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

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

Did the patient self-medicate for today's procedure?

❑ Yes ❑ No

If yes, do they have a driver? ❑ Yes ❑ No

❑ Patient unaware of current medications ❑ Patient not on any medications

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: _____

Technologist Comments: _____

_____

_____

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. _____