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

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

** **Pregnant** ☐ Yes ☐ No

* **Implanted Neurostimulator** ☐ 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

Tattoos and/or Body Piercing ☐ Yes ☐ No

Hearing Aid ☐ Yes ☐ No

Clothing with Dri Weave, Dri Fit or Wicking Feature ☐ Yes ☐ No

Medication Skin Patches ☐ Yes ☐ No

History of Cancer ☐ Yes ☐ No

If yes, what type? _____

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

If not listed above, notify the Technologist.

Claustrophobic? ☐ Yes ☐ No

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

Does patient have a driver? ☐ N/A ☐ Yes ☐ No

Please list all past surgeries and their dates:

_____

_____

_____

I have answered the questions above 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: _____

Diagnosis: _____

Reason for Exam/Clinical Symptoms: _____

Clinical Pause #1: Correct Patient ☐ Correct Procedure ☐ Correct Body Part ☐ Lowest SAR Utilized ☐

Technologist Comments _____

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

Non-Alliance staff accompanying patient received:

- MRI Safety training? ..... ☐ Yes ☐ No
- Verbal safety screening per policy..... ☐ Yes ☐ No

Patient's preferred language for discussing healthcare

☐ English ☐ Spanish ☐ Other _____

Last Name _____

First Name _____

Date of Birth _____ **Date** _____

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
Any Falls within past 30 days?..... ☐ Yes ☐ No
If Yes, when _____
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.

	Taken Today		Taken Today
_____	☐	_____	☐
_____	☐	_____	☐
_____	☐	_____	☐
_____	☐	_____	☐
_____	☐	_____	☐
_____	☐	_____	☐

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

Did 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 Used
☐ Hearing	☐ Repeat Questions
☐ Other _____	☐ 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 team member to follow policy #5023.

Tech Comments: _____

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 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 Team Members? ..... ☐ Yes ☐ No ☐ EMR
If yes to above and NOT documented in an EMR or Intergy, complete the two rows below.

Team Member Name: _____ Date: _____ Time: _____

Summary of Phone Conversation: _____

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

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.**

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 _____