

MRI Patient Screening Form - Part A

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

Height: _____ Weight: _____ lbs./kg.

Patient Address: _____

City, State, Zip: _____

Last Name _____

First Name _____

Date of Birth _____ Date _____

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

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 _____

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

If not listed above, notify the Technologist.

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 _____

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 asterisk (***) questions. Double asterisk (**) require a signed informed consent. Single asterisk (*) 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

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

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

Does patient have a driver?..... N/A 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, 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
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

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:

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 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 row below.

Team Member Name: _____ Date: _____ Time: _____

Summary of Phone Conversation: _____

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. _____