

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

***LVAD Device (Heart Pump) Yes No

***Breast Tissue Expanders Yes No

**Existing Pacemaker or Pacemaker wires Yes No

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

**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

I have answered the questions above accurately.

Signature of Patient: _____ Date: _____ Time: _____

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

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 _____

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 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
 Reviewed Referring Physician Order Correct Positioning Tech Initials _____

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:
<input type="checkbox"/> Language	<input type="checkbox"/> Interpreter ID# _____
<input type="checkbox"/> Hearing	<input type="checkbox"/> Repeat Questions
<input type="checkbox"/> Other _____	<input type="checkbox"/> 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

Patient received ear protection. Yes No If no, complete release form A030.

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.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
I give my consent to receive electronic communications & survey invitations. <i>(Data rates may apply depending on your mobile carrier.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
My preferred method to receive communications and survey is:	<input type="checkbox"/> Text Msg <input type="checkbox"/> E-mail <input type="checkbox"/> Tablet
Cell #: (____) _____	E-mail: _____
I have received a copy of the terms and conditions for electronic communication.	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Patient Signature _____