

# MRI Patient Screening Form - Part A

Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ Emergency Contact Name and Phone Number: \_\_\_\_\_  
 Patient Height: \_\_\_\_\_ Patient Weight: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Reason for Exam: \_\_\_\_\_  
 Please list previous surgeries and their dates \_\_\_\_\_

**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

I have answered the questions above accurately.

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 \_\_\_\_\_

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 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

## ***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** \_\_\_\_\_

 **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: \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date \_\_\_\_\_