

HH 515H MR

MRI EXAMINATION AND PATIENT SCREENING FORM

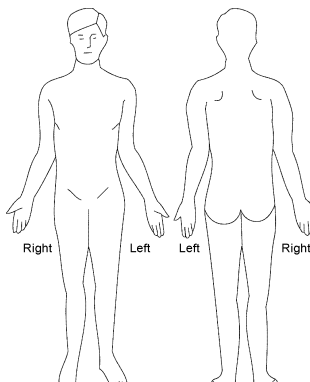
- Inpatient
- Outpatient
- ED

NAME _____

MEDICAL RECORD #: _____

BIRTHDATE _____

PCP: _____

AREA TO BE EXAMINED / TYPE OF EXAMINATION DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED) <i>Rule out diagnosis not acceptable</i>	SCHEDULED DATE: _____ FLOOR/CLINIC _____	ATTENDING PHYSICIAN: _____ Resident/PA: _____ Signature _____ Print _____ Beeper #: _____
ICD-9 CODES HISTORY / CLINICAL INFORMATION (REQUIRED) SIGNS, SYMPTOMS	WHEELCHAIR <input type="checkbox"/> CART <input type="checkbox"/> I-MED <input type="checkbox"/> O ₂ <input type="checkbox"/> VENTED <input type="checkbox"/>	<div style="text-align: center;">  <p>PLEASE SHADE IN AREA OF INTEREST</p> </div>
		FOR MRI USE ONLY PROTOCOL #: _____ Initials _____

THIS FORM MUST BE COMPLETED TO ENSURE PATIENT SAFETY

PATIENT SAFETY SCREENING: Has patient had prior MRI scan at Highland Hospital No Yes Date: _____

Is the patient claustrophobic? No Yes Will the patient need sedation? No Yes

Ht: _____ Wt: _____ Able to lie flat No Yes If no, reason _____

Have you ever had IV MR contrast (Gadolinium)? No Yes Any problems/reactions _____

Possibility of Pregnancy? No Yes LMP Date _____

Does patient have: **Cardiac Pacemaker** No Yes **Implant Defibrillator** No Yes

Swan-Ganz Catheter No Yes **Intracranial Aneurysm Clips** No Yes

Brain/Head Surgery: No Yes List type/date _____

Heart/Chest Surgery: No Yes List type/date _____

Ear Surgery: No Yes List type/date _____

Eye Surgery: No Yes List type/date _____

Other Surgery: No Yes List type/date _____

Artificial Implants: No Yes List type/date _____

History: Kidney disease No Yes Seizures No Yes Asthma No Yes

Dentures/partial No Yes Hearing Aid No Yes Hair Piece No Yes

Hx of Metal Fragments in Eye No Yes Bullets, Shrapnel, BB No Yes Pierced body parts No Yes

Bullet, etc. area _____ Pierced area _____

Drug allergies/reaction _____

Screening info obtained from (please check): Patient Chart Reliable family member: relationship _____

Your Name (Print) _____ Signature _____ Date _____

Scheduling Exam: 585-341-6586 Mailing Address: Highland Hospital
 Outpatient FAX: 585-341-8014 MRI Department
 1000 South Avenue
 Rochester, NY 14620

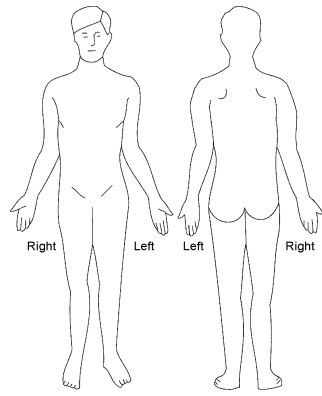
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