

**SMH 515**

**MRI EXAMINATION AND PATIENT SCREENING FORM**

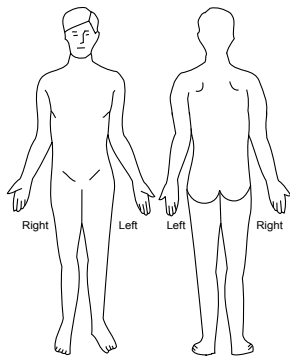
- INPATIENT
- OPD
- ED

NAME:

MEDICAL RECORD #:

BIRTHDATE:

PCP:

<b>AREA TO BE EXAMINED / TYPE OF EXAMINATION:</b> _____ _____	<b>SCHEDULED DATE:</b> _____ <b>FLOOR/CLINIC</b> _____	<b>SEND PHYSICIAN'S PERSONAL COPY TO:</b> NAME: _____ M.D. FIRST LAST ADDRESS STREET CITY ZIP <b>PHYSICIAN'S SIGNATURE</b> ATTENDING _____ BEEPER _____ RESIDENT _____
<b>DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED)</b> Rule out diagnosis not acceptable	WHEELCHAIR <input type="checkbox"/> CART <input type="checkbox"/> I-MED <input type="checkbox"/> O <sub>2</sub> <input type="checkbox"/> VENTED <input type="checkbox"/>	<b>ICD-9 CODES</b> _____ <b>HISTORY / CLINICAL INFORMATION (REQUIRED)</b> SIGNS, SYMPTOMS _____ _____ _____
<b>Most Recent Lab Values:</b> _____ <b>BUN:</b> _____ <b>Creatinine:</b> _____	 <p>PLEASE SHADE IN AREA OF INTEREST</p>	<b>FOR MRI USE ONLY</b> PROTOCOL: _____ Initials _____ <b>RADIOLOGY PRELIMINARY REPORT:</b> _____ Initials _____

**THIS FORM MUST BE COMPLETED TO ENSURE PATIENT SAFETY**

**PATIENT SAFETY SCREENING:** Has patient had prior MRI Scan at Strong Memorial Hospital?  Yes  No Date: \_\_\_\_\_

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

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

Have you ever had IV MR contrast (Gadolinium)?  Yes  No Any Problems/Reactions \_\_\_\_\_

Possibility of Pregnancy?  Yes  No LMP Date \_\_\_\_\_

**Does patient have:** **Cardiac Pacemaker**  Yes  No **Implanted Defibrillator**  Yes  No  
**Swan-Ganz Catheter**  Yes  No **Intracranial Aneurysm Clips**  Yes  No

**Brain/Head Surgery:**  Yes  No List type/date \_\_\_\_\_

**Heart/Chest Surgery:**  Yes  No List type/date \_\_\_\_\_

**Ear Surgery:**  Yes  No List type/date \_\_\_\_\_

**Eye Surgery:**  Yes  No List type/date \_\_\_\_\_

**Other Surgery:**  Yes  No List type/date \_\_\_\_\_

**Artificial Implants:**  Yes  No List type/date \_\_\_\_\_

**History:** Anemia (sickel cell, hemolytic)  Yes  No Bullets, Shrapnel, BB  Yes  No Hx of Metal Fragments  Yes  No  
 Seizures  Yes  No Bullet, etc. area \_\_\_\_\_  Yes  No in Eye  Yes  No  
 Kidney disease  Yes  No **Transdermal Medical Patch**  Yes  No Dentures/Partials  Yes  No  
 Asthma  Yes  No Pierced body parts  Yes  No Hearing Aid  Yes  No  
 Pierced area \_\_\_\_\_  Yes  No Hair Piece  Yes  No

Drug allergies/reaction \_\_\_\_\_

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

Discharge instructions given  Yes  No Form Verbal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Reviewed by RN/Technologist \_\_\_\_\_ Date: \_\_\_\_\_

Your Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Scheduling Exam: (585) 275-5351** **Mailing Address: Strong Memorial Hospital**  
**Outpatient Fax: (585) 273-1060** **Magnetic Resonance Center, Box 694**  
**Inpatient Fax: 273-3146** **Rochester, NY 14642-8694**

**Preprocedure Time Out:**  Consent obtained:  Correct pt (use 2 identifiers)

Correct procedure  Correct site Site marked:  Y  N  N/A

Correct pt position  Equipment/implants available:  N/A

List participant(s) in time out:  
 I \_\_\_\_\_ II \_\_\_\_\_ III \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

SH 10909 MR (Rev. 6/05)

IV: \_\_\_\_\_ IVDc'd: \_\_\_\_\_ Site intact: \_\_\_\_\_ Other: \_\_\_\_\_  
 (time, type, site, initials) (time, initials)

**MRI USE ONLY**

Date	Medication	Dosage	Route	Time	MD / RN Signature

Discharge instructions given  No  Yes Reviewed by RN/Tech Signature \_\_\_\_\_ Date \_\_\_\_\_

Radiologist's Comment \_\_\_\_\_

Radiologist Signature \_\_\_\_\_ Date \_\_\_\_\_

EXAM #1

EXAM #2

ROOM	TECHNOLOGIST
QUALITY CONTROL	# OF FILMS
DISK#	MR#
<b>MR TECHNOLOGIST -</b> ADD'L INFO REGARDING PT'S CONDITION:	