

SMH 515

MRI EXAMINATION AND PATIENT SCREENING FORM

INPATIENT

OPD

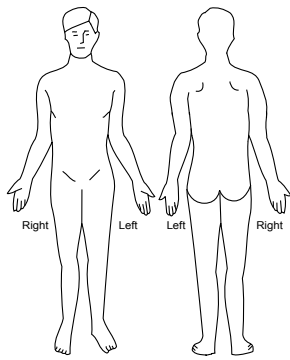
ED

NAME:

MEDICAL RECORD #:

BIRTHDATE:

PCP:

AREA TO BE EXAMINED / TYPE OF EXAMINATION:	SCHEDULED DATE:	SEND PHYSICIAN'S PERSONAL COPY TO:	
	FLOOR/CLINIC	NAME:	M.D.
DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED) Rule out diagnosis not acceptable	WHEELCHAIR <input type="checkbox"/>	FIRST	LAST
	CART <input type="checkbox"/>	ADDRESS	
	I-MED <input type="checkbox"/>	STREET	CITY ZIP
	O ₂ <input type="checkbox"/>	PHYSICIAN'S SIGNATURE	
VENTED <input type="checkbox"/>	ATTENDING	BEEPER	
ICD-9 CODES			FOR MRI USE ONLY
HISTORY / CLINICAL INFORMATION (REQUIRED) SIGNS, SYMPTOMS			PROTOCOL:
Most Recent Lab Values: _____			Initials _____
BUN: _____ Creatinine: _____			RADIOLOGY PRELIMINARY REPORT:
			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
 Outpatient Fax: (585) 273-1060
 Inpatient Fax: 273-3146

Mailing Address: Strong Memorial Hospital
 Magnetic Resonance Center, Box 694
 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#
MR TECHNOLOGIST - ADD'L INFO REGARDING PT'S CONDITION:	