

MRI EXAMINATION AND PATIENT SCREENING FORM

- INPATIENT
- OPD
- ED

NAME:

MEDICAL RECORD #:

BIRTHDATE:

PCP:

<p>AREA TO BE EXAMINED / TYPE OF EXAMINATION:</p>	<p>SCHEDULED DATE:</p>	<p>SEND PHYSICIAN'S PERSONAL COPY TO:</p> <p>NAME: _____ M.D.</p> <p style="text-align: center;">FIRST LAST</p>
<p>DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED) Rule out diagnosis not acceptable</p>	<p>FLOOR/CLINIC _____</p> <p>WHEELCHAIR <input type="checkbox"/></p> <p>CART <input type="checkbox"/></p> <p>I-MED <input type="checkbox"/></p> <p>O₂ <input type="checkbox"/></p> <p>VENTED <input type="checkbox"/></p>	<p>ADDRESS _____</p> <p>STREET CITY ZIP _____</p> <p>PHYSICIAN'S SIGNATURE</p> <p>ATTENDING _____ BEEPER</p> <p>RESIDENT _____</p>
<p>ICD-9 CODES</p>		
<p>HISTORY / CLINICAL INFORMATION (REQUIRED) SIGNS, SYMPTOMS</p>	<p>FOR MRI USE ONLY</p> <p>PROTOCOL: _____</p> <p style="text-align: right;">Initials _____</p> <hr/> <p>RADIOLOGY PRELIMINARY REPORT:</p> <p style="text-align: right;">Initials _____</p>	

THIS FORM MUST BE COMPLETED TO ENSURE PATIENT SAFETY

PATIENT SAFETY SCREENING: Has patient had prior MRI Scan at Strong Memorial 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 <input type="checkbox"/> No <input type="checkbox"/> Yes	Implanted Defibrillator <input type="checkbox"/> No <input type="checkbox"/> Yes
Swan-Ganz Catheter <input type="checkbox"/> No <input type="checkbox"/> Yes	Intracranial Aneurysm Clips <input type="checkbox"/> No <input type="checkbox"/> 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/Partials 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) 275-5351
 Outpatient Fax: (585) 273-1060
 Inpatient Fax: 273-3146

Mailing Address: Strong Memorial Hospital
 Magnetic Resonance Center, Box 694
 Rochester, NY 14642-8648

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

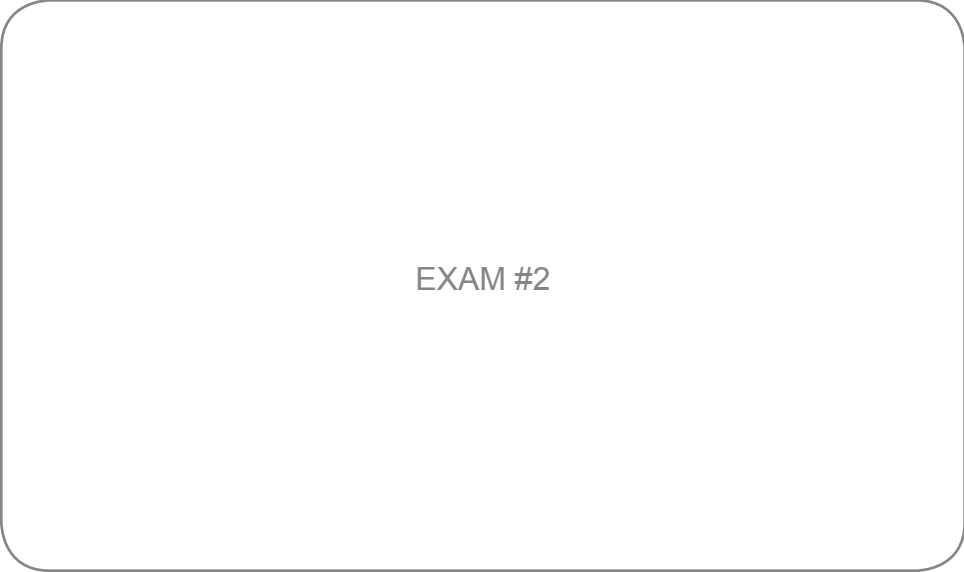
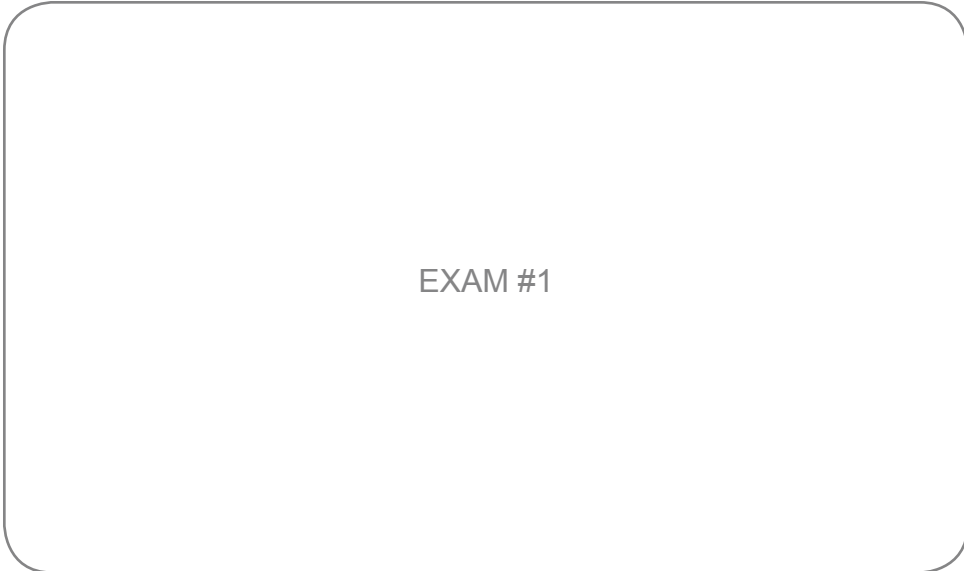
MRI USE ONLY

Date	Medication	Dosage	Route	Time	MD / RN Signature
	GADOLINIUM		IV		

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

Radiologist's Comment _____

Radiologist Signature _____ Date _____



ROOM	TECHNOLOGIST
QUALITY CONTROL	# OF FILMS
DISK#	MR#

MR TECHNOLOGIST -
 ADD'L INFO REGARDING PT'S CONDITION:

