

MRI EXAMINATION AND PATIENT SCREENING FORM

- INPATIENT
- OPD
- ED

NAME:

MEDICAL RECORD #:

BIRTHDATE:

PCP:

<p>AREA TO BE EXAMINED / TYPE OF EXAMINATION:</p> <p style="text-align: center; font-size: 1.2em;">MRI OF BRAIN</p>	<p>SCHEDULED DATE:</p> <hr/> <p>FLOOR/CLINIC</p>	<p>SEND PHYSICIAN'S PERSONAL COPY TO:</p> <p>NAME: _____ M.D.</p> <p style="text-align: center;">FIRST LAST</p> <hr/> <p>ADDRESS _____</p> <p>STREET CITY ZIP</p> <hr/> <p>PHYSICIAN'S SIGNATURE</p> <p>ATTENDING _____</p> <p style="text-align: right;">BEEPER</p> <hr/> <p>RESIDENT _____</p>
<p>DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED)</p> <p style="color: red;">Rule out diagnosis not acceptable</p> <p style="font-size: 1.2em; font-weight: bold;">Evaluation for Alzheimer's Disease</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>FOR MRI USE ONLY</p> <p>PROTOCOL: #220 - to be done on the Twin-Speed Magnet</p> <p style="text-align: right;">Initials _____</p> <hr/> <p>RADIOLOGY PRELIMINARY REPORT:</p> <p style="text-align: right;">Initials _____</p>
<p>ICD-9 CODES</p> <p style="font-size: 1.5em; font-weight: bold;">331.0</p>	<p>PLEASE SHADE IN AREA OF INTEREST</p>	
<p>HISTORY / CLINICAL INFORMATION (REQUIRED)</p> <p>SIGNS, SYMPTOMS</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 <input type="checkbox"/> No <input type="checkbox"/> Yes	Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes
Dentures/Partials <input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing Aid <input type="checkbox"/> No <input type="checkbox"/> Yes	Hair Piece <input type="checkbox"/> No <input type="checkbox"/> Yes
Hx of Metal Fragments in Eye <input type="checkbox"/> No <input type="checkbox"/> Yes	Bullets, Shrapnel, BB <input type="checkbox"/> No <input type="checkbox"/> Yes	Pierced body parts <input type="checkbox"/> No <input type="checkbox"/> 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
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