STRONG HEALTH

STRONG MEMORIAL HOSPITAL

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:

FLOOR/CLINIC

SEND PHYSICIAN'S PERSONAL COPY TO:

NAME: FIRST LAST M.D.

ADDRESS STREET CITY ZIP

PHYSICIAN'S SIGNATURE

ATTENDING BEEPER

RESIDENT

DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED)
Rule out diagnosis not acceptable

WHEELCHAIR ☐
CART ☐

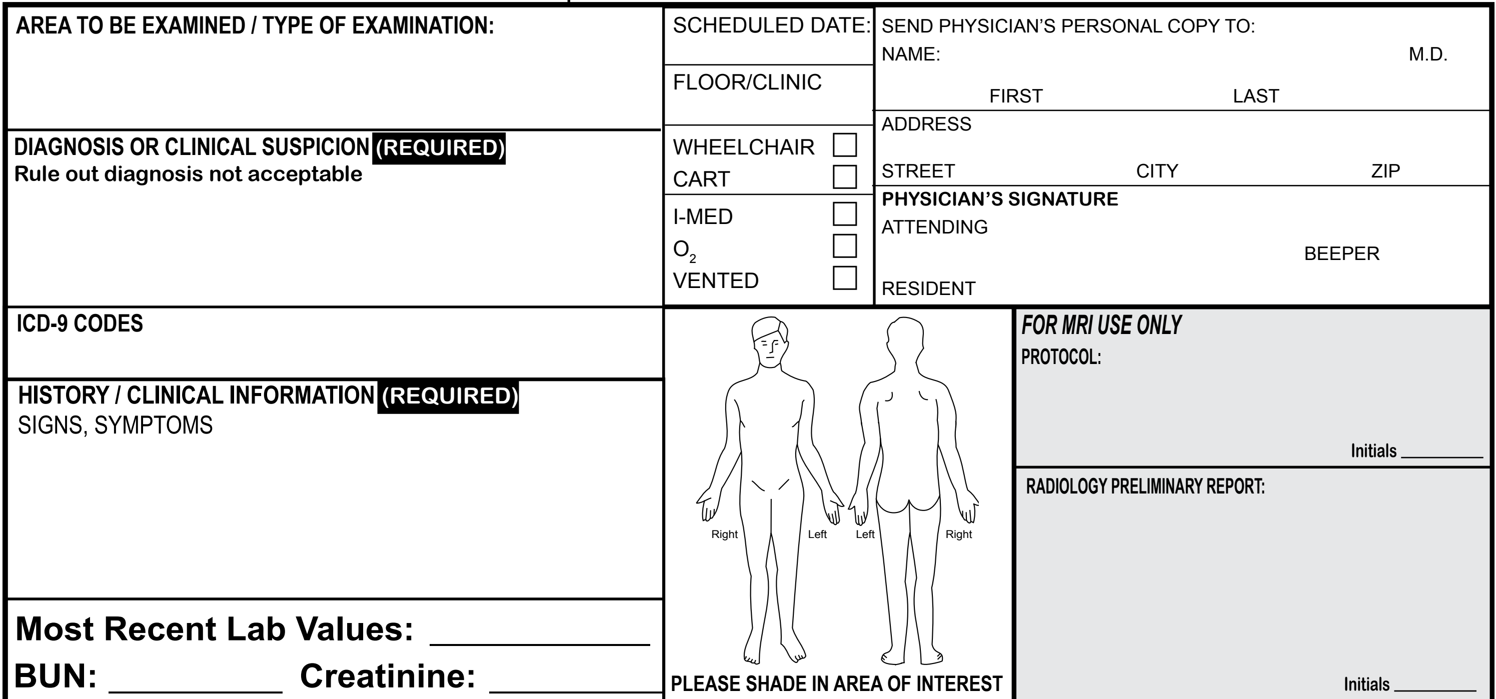
I-MED ☐
O_2 ☐
VENTED ☐

ICD-9 CODES

HISTORY / CLINICAL INFORMATION (REQUIRED)
SIGNS, SYMPTOMS

Most Recent Lab Values: ____________

BUN: __________ **Creatinine:** ____________



PLEASE SHADE IN AREA OF INTEREST

FOR MRI USE ONLY

PROTOCOL:

Initials ________

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 **Implated 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 in Eye	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Bullet, etc. area ______	☐ 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

6/06

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 ______

ROOM	TECHNOLOGIST
QUALITY CONTROL	# OF FILMS
DISK#	MR#

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

EXAM #1

EXAM #2