MRI Scheduling & Safety Form

Patient Name: _____
Ordering Physician: _____
MRI Exam: _____
Diagnosis:_____
Any Surgery to Area Being Scanned& Date Done:___
_____
Personal History of Cancer: ___ **Weight**:_____ **HT**: ____ **Translation Service Needed for Patient?** ___

Safety Questions

Yes No

___ ___ Any Surgery in the past 6- 8 weeks
___ ___ Cardiac Pacemaker or Defibrillator
___ ___ Remaining Electrodes or Pacing Wires
___ ___ Aneurysm Clips
___ ___ Cochlear Implants
___ ___ Inner Ear Surgery
___ ___ Insulin or Medication Pumps
___ ___ Deep Brain Neurostimulators
___ ___ Brain Surgery
___ ___ Neurostimulators (Spinal etc…)
___ ___ Any Shunts/Stents/Filters

If Yes Obtain Info Regarding Stent etc.

_____

If Yes, or Questions Stop! Consult with tech

If MRI Exam is Ordered With Contrast

YES NO

___ ___ Patient is over 59
___ ___ Patient is known Diabetic
___ ___ Patient has known history of Liver Disease
___ ___ Patient has known history of Kidney Disease
___ ___ Any History of blood or Autoimmune Disorders (i.e. Mult. Myelo. or Lupus
___ ___ **Does Patient Currently takes any Meds for Any of the above Disorders or Disease's**

If Yes, Stop! ___ Patient ___ Provider

Has been instructed that an Creatinine/eGFR & Bicarbonate lab levels must be performed within the last 30 days prior to the exam/scan

Has patient had contrast before? ___
Any Complications from MRI Contrast? ____
Describe Incident _____
_____

YES NO

___ ___ Eye Surgery
___ ___ Shrapnel or metal in the Body
___ ___ Hearing Aid
___ ___ Dentures / Braces
___ ___ Heart Surgery
___ ___ Artificial Heart Valve
___ ___ Metal Mesh
___ ___ Metal Rods Pins / Plates / Staples etc……
___ ___ Medication Patches (Need To be Removed)
___ ___ Joint Replacement
___ ___ Prosthesis (Leg, Eye, Penile, etc…)
___ ___ I.U.D. or other Contraceptive Devices
___ ___ Physical Disabilities (W/C etc….)
___ ___ Body Piercings (earrings etc…)
___ ___ Tattoos
___ ___ Pregnant
If having a Breast MRI need Date of Last Menstrual Cycle: ____/____/____
___ ___ Breastfeeding
___ ___ Claustrophobic
___ ___ Sedation Needed (Oral) *Does Patient have a driver to take them home? _____
___ ___ Do you have Sleep apnea (If sedation is used)

Does Patient Work with metal or Grind? Has the patient had a Metal Injury to the eyes?
YES ____ No ____ **HAVE ORBIT X-RAYS BEEN OBTAINED**? YES ___ No ___

Diagnostic Studies Related to this MRI Exam:

	YES	No
Previous MRI Exam:	___	___

If Yes Where & When _____
_____

Is Patient Bringing to Appt.? _____
Has the exam been Sent for? _____ When? _____

Patient Signature: _____ Date Verified: _____
Technologist Signature: _____ Date Verified: _____