MRI - Part A

Factors such as weight, body shape and scan type may determine if scan can be performed.

Height: _____ Weight: _____ lbs./kg.

Last Name _____

First Name _____

Date of Birth _____ Date _____

Patient safety is our primary concern. The MRI room contains a very strong magnet and is ALWAYS on. Before you are allowed to enter the MRI room, we must know if you have any metal in or on your body. You MUST remove all metallic objects including cell phone, keys, watches, hair pins, pocket knives, lighters, bank cards, purses, wallets, jewelry, etc. Hearing aids must be removed immediately before entering the MRI room. Failure to remove such items can result in serious damage to those items and/or injury to yourself and others. Please answer the following questions carefully.

I have read and understand the above information, and have removed all metal.... ☐ Yes ☐ No

Medical/Dental Procedures with sedation in the past 24 hours?.... ☐ Yes ☐ No

*** Small Bowel Endoscopy Capsule.... ☐ Yes ☐ No

***LVAD Device (Heart Pump).... ☐ Yes ☐ No

***Breast Tissue Expanders.... ☐ Yes ☐ No

**Existing Pacemaker or Pacemaker wires ☐ Yes ☐ No

**Implanted Cardiac Defibrillator.... ☐ Yes ☐ No
(past or present)

**Pregnant.... ☐ Yes ☐ No
Last Menstrual Period _____

*Implanted Neurostimulator.... ☐ Yes ☐ No

*Artificial Heart Valves/Heart Stents.... ☐ Yes ☐ No
Date: _____ Make: _____
Model: _____

*Surgical/Vascular Clips/Grafts/Stents.... ☐ Yes ☐ No
Type: _____

*Aneurysm Clips.... ☐ Yes ☐ No

*Recent colonoscopy or digestive system procedure involving surgical clips.... ☐ Yes ☐ No

*Medication Pump.... ☐ Yes ☐ No

*External TENS Unit.... ☐ Yes ☐ No

*Metallic Foreign Body (Gun shot wounds, retinal buckle, etc.).... ☐ Yes ☐ No

*Eye injury involving Metal.... ☐ Yes ☐ No

*Prior Ear, Eye or Brain Surgery.... ☐ Yes ☐ No

*Catheter, Drainage Tube, Temp Monitor.... ☐ Yes ☐ No

Hearing Aids.... ☐ Yes ☐ No

Dri Weave, Dri Fit or Wicking Clothing.... ☐ Yes ☐ No

Medication Skin Patches.... ☐ Yes ☐ No

History of Cancer.... ☐ Yes ☐ No
If yes, what type? _____

Joint Replacement/Joint Implants.... ☐ Yes ☐ No

Orthopedic or Prosthetic Devices.... ☐ Yes ☐ No

Vena Cava Umbrella Filter.... ☐ Yes ☐ No

Hair Extensions/Hair Pieces/Wig.... ☐ Yes ☐ No

Braces, Oral Springs, Removable Dental Work.... ☐ Yes ☐ No

Glitter/Permanent Eye Makeup.... ☐ Yes ☐ No

Anything Held with Magnets or Pins.... ☐ Yes ☐ No

Tattoos and/or Body Piercing.... ☐ Yes ☐ No

Claustrophobic?.... ☐ Yes ☐ No

Iron Deficiency being treated w/ Feraheme ☐ Yes ☐ No

History of Epilepsy (seizures).... ☐ Yes ☐ No

History of Diarrhea in past 2-3 days.... ☐ Yes ☐ No

Any falls within past 30 days?.... ☐ Yes ☐ No
If yes, when: _____

Anything in or on your body that you weren't born with?
☐ Yes ☐ No If not listed above, notify the Technologist.

Did you pre-medicate for this exam?.... ☐ Yes ☐ No

Do you have a driver?.... ☐ N/A ☐ Yes ☐ No

Please list all past surgeries and their dates:

_____

_____

Any previous imaging study related to the reason for today's exam?.... ☐ Yes ☐ No

Type of Exam _____

Facility _____

Date _____

I have answered the questions above accurately.

Signature of Patient: _____ Date: _____ Time: _____
(Parent or Guardian if patient is a Minor or Incapacitated) Relationship: _____

MRI CANNOT be performed if **"Yes"** is answered to triple asterisked (***) questions. Double asterisked (**) require a signed informed consent. Single asterisked (*) may require further discussion between the Radiologist & Technologist. Document any verbal approvals/instructions on Part B.

I have reviewed each response with the patient or their legal guardian, power of attorney, next of kin, etc. and PERFORMED CLINICAL PAUSE #1.

Technologist's Signature: _____ Date: _____

Revised January, 2019

Attachment A007

MRI - Part B

Medical Record # / Accession #: _____
Referring Physician: _____
Exam Ordered - MRI of: _____
Diagnosis: _____
Facility Name: _____

Last Name _____
First Name _____
Date of Birth _____ **Date** _____

Reason for Exam/Clinical Symptoms: _____

Clinical Pause #1: Correct Patient ☐ Correct Procedure ☐ Correct Body Part ☐ Lowest SAR Utilized ☐
Reviewed Referring Physician Order ☐ Correct Positioning ☐ Tech Initials _____

Patient's preferred language for discussing healthcare: ☐ English ☐ Spanish ☐ Other _____

Allergies to any medications, food, or latex? ..... ☐ Yes ☐ No Please List: _____
List all current medications including all prescriptions, over the counter items, ointments, vitamins, and herbals. Attach list if available.

Check the box for any medications taken today.

_____ ☐ _____ ☐ _____ ☐ _____ ☐
_____ ☐ _____ ☐ _____ ☐ _____ ☐

☐ Patient unaware of current medications ☐ Patient not on any medications ☐ Medication list attached (includes name & DOB)

Will the patient receive an IV injection? ☐ Yes ☐ No
If yes, attachment A054 must be completed and signed.
Injection site evaluated? ☐ Yes ☐ No ☐ N/A Note appearance: _____
Post Injection Instructions given
(applicable to all patients who receive an injection)..... ☐ Yes ☐ No ☐ N/A

Barriers to Learning ☐ Yes ☐ No

Type:	**Interventions:**
☐ Language	☐ Interpreter ID# _____
☐ Hearing	☐ Repeat Questions
☐ Other _____	☐ Family/Significant Other

RECEIPT OF VERBAL ORDERS, TEST RESULTS, MODIFICATIONS, OR OTHER INSTRUCTIONS ☐ Yes ☐ No

Information Received: _____
Readback confirmed with _____ Title _____ Date _____ Time _____
Technologist Signature _____ Date _____ Time _____
Radiologist Signature _____ Date _____ Time _____

Patient was encouraged to "Speak Up" with questions or concerns..... ☐ Yes ☐ No
Patient received ear protection. ☐ Yes ☐ No If no, complete release form A030.

Clinical Pause #2 conducted prior to image transfer (Correct labeling, annotation and image quality)? ☐ Yes ☐ No Tech Initials _____

Prior to release, patient was assessed and found impaired? ☐ Yes ☐ No If yes, supervising physician notified? ☐ Yes ☐ No
If patient refuses further assessment, notify supervising physician and team member to follow policy #5023.

Tech Comments: _____

Team Member Signature and Title: _____

PATIENT SIGNATURE BELOW ONLY AT THE COMPLETION OF EXAM.

I retrieved all of my personal belongings upon completion of exam. ❑ Yes ❑ No ❑ N/A
I give my consent to receive electronic communications & survey invitations. ❑ Yes ❑ No ❑ N/A
(Data rates may apply depending on your mobile carrier.)
My preferred method to receive communications and survey is: ❑ Text Msg ❑ E-mail ❑ Tablet
Cell #: (____) _____ E-mail: _____
I have received a copy of the terms and conditions for electronic communication.
❑ Yes ❑ No ❑ N/A **Patient Signature** _____

ALLIANCE HEALTHCARE RADIOLOGY

Last Name _____

First Name _____

Date of Birth _____

MRI PRE-CONTRAST SCREENING FOR IV CONTRAST

Your physician or radiologist may deem it necessary for you to have an IV injection of a contrast agent containing gadolinium to improve the quality of your MR examination.

Although gadolinium contrast agents have been used safely in millions of patients, minor reactions (principally headache or nausea), and serious or life threatening reactions may occur.

Have you ever had an injection of contrast before? ☐ Yes ☐ No
Have you ever had a previous reaction to contrast? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently breastfeeding? ☐ Yes ☐ No
Do you have a history of Diabetes? ☐ Yes ☐ No
Do you have Asthma? ☐ Yes ☐ No
Do you have a history of High Blood Pressure? ☐ Yes ☐ No
Are you receiving treatment for Gout? ☐ Yes ☐ No
Do you have a history of breast cancer with lymph nodes removed? ☐ Yes ☐ No
Do you have a history of arterio-venous (AV) fistula? ☐ Yes ☐ No
Do you have a history of Dialysis/Kidney Failure/Renal Insufficiency? ☐ Yes ☐ No
(Tech- If GFR is 30 or less, also utilize Attachment A047- Consent for Gadolinium in Patients with End Stage Renal Disease)

The technologist has explained the procedure to me, I have received and read the medication guide for the gadolinium based contrast agent that may be used as part of my MRI examination and I have had my questions answered.
I agree to have the MRI procedure with injection of contrast if deemed necessary.

_____ _____ _____
Signature of Patient (Parent or Guardian if patient is a minor or incapacitated) **Date** **Time**

Signature of Technologist _____

GFR _____ (Document any contrast protocol modification on Part B)
Creatinine _____ Reference Range_____-_____ Date_____

Contrast Name _____ Amount _____mL Lot # _____
Contrast Expiration Date _____ Contrast NDC # _____
Injection Site _____ Flow Rate _____
Multi-dose vial ☐ or Single-dose vial ☐ ? If single dose vial, amount of discarded contrast _____ mL
IV Device Used _____ Time of Injection_____ Tech Initials _____

ALLIANCE HEALTHCARE RADIOLOGY

OUT-PATIENT FALL RISK ASSESSMENT

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ SITE NAME: Diagnostic Health Alaska

INTERVIEWER NAME: _____ CUSTOMER NUMBER: _____

Patient: The following questions are intended to identify patients who may be at risk of falling and to help avoid potential injury. This procedure has been implemented to ensure your safety and to enable us to provide you with the best possible patient care.
Please circle the appropriate answer to each question below. Our staff will go over these questions with you prior to your examination to address any questions or concerns you may have.

1. Have you fallen recently (within the last 3 months)?	YES	NO
2. Do you use a cane, walker or other device to help you walk?	YES	NO
3. Do you require assistance to stand up?	YES	NO
4. Have you taken any medications today for anxiety or to relax you? If yes, what medication? _____ Dosage _____ Time _____	YES	NO
5. Are you dizzy, lightheaded, weak in your legs or unable to see or hear clearly?	YES	NO

Team Member: All patients must be assessed for falls risk prior to transporting patients from the waiting area. If the patient, patient's family member or caregiver answers "yes" to any of the above questions, transport the patient via wheelchair to the imaging system or exam/treatment room.
Retention:

- Wheelchair Refusal: When the fall risk assessment determines a patient must use a wheelchair and the patient refuses, the entire form must be completed, signed and retained in the patient's medical record.
- Mobile Units Only- If the lift or roll/slide door is inoperable and the unit's stairs must be utilized, the top portion of this document must be completed and retained in the patient's medical record. If any "yes" answers are provided, the patient may not utilize the mobile unit stairs and must reschedule for a time when the lift/roll/slide door is operable.

RELEASE OF LIABILITY

Notwithstanding the evaluated risk of fall and Alliance's offer/recommendation to use a wheelchair for transport to/from the imaging system or exam/treatment room, I decline the use of a wheelchair. By declining the use of wheelchair for transport to/from the imaging system or exam/treatment room, I agree, acknowledge and assume all inherent risk including but not limited to the risk of falling, personal injury, damage to personal property, or otherwise. I, on behalf of myself, heirs and/or representatives, do hereby waive and agree to release and hold harmless Alliance HealthCare Services, Inc., its officers, agents, subsidiaries and employees from any and all liability for any damage, claim or injury to myself or my property or otherwise.

PATIENT SIGNATURE: _____

_____ _____

WITNESS SIGNATURE: TITLE

