MRI Part A - RETAIL

Last Name: _____

First Name: _____

DOB: _____ Date: _____

Height _____ Weight _____ lbs/kgs

The MRI room contains a very strong magnet and is ALWAYS on. You MUST remove all metallic objects. 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.

Medical/Dental procedures in the past 24 hours?	☐ Yes ☐ No
LVAD heart pump, pacemaker or pacer wires, defibrillator?	☐ Yes ☐ No
Implanted neurostimulator or TENS unit?	☐ Yes ☐ No
Medication injection device (OnPro) or pump?	☐ Yes ☐ No
Artificial heart valves/stents or aneurysm/vascular clips/grafts/shunts?	☐ Yes ☐ No
Breast tissue expander, metallic foreign body, bullet/shrapnel or any eye injury involving metal?	☐ Yes ☐ No
Small bowel endoscopy capsule or Vena Cava umbrella filter?	☐ Yes ☐ No
Recent colonoscopy or digestive system procedure involving surgical clips?	☐ Yes ☐ No
Catheter- drainage tube or temperature monitor?	☐ Yes ☐ No
Prior ear, eye or brain surgery?	☐ Yes ☐ No
Hearing aids or Medication skin patches?	☐ Yes ☐ No
Pregnant? LMP:	☐ Yes ☐ No
Joint Replacement or orthopedic/prosthetic device?	☐ Yes ☐ No
History of Cancer? If yes, what type	☐ Yes ☐ No
Hair extensions/wig, braces, oral springs, removable dental work or anything held with magnets or pins?	☐ Yes ☐ No
Tattoos/Body Piercings, Glitter/permanent makeup?	☐ Yes ☐ No
DriWeave, Dri Fit or wicking clothing?	☐ Yes ☐ No
Iron deficiency being treated with Feraheme?	☐ Yes ☐ No
History of seizures or any recent falls? If yes, when?	☐ Yes ☐ No
Diarrhea in past 2-3 days?	☐ Yes ☐ No
Claustrophobia?	☐ Yes ☐ No
Anything in or on your body that you weren't born with?	☐ Yes ☐ No

GENERAL CONSENT/ACKNOWLEDGEMENT

I consent to the ordered exam. I understand that I have the right to refuse or stop the exam at any time and I have the right to ask questions and discuss my concerns.

I have read the screening information and answered the above safety questions accurately, and I understand I MUST REMOVE ALL METAL prior to my MRI examination.

I authorize Alliance Healthcare Services, Inc., its subsidiaries and affiliates to bill on my behalf Medicare, or any other insurance company providing benefits to me, for services performed by Alliance and I authorize payment to be made directly to Alliance. In Medicare assigned cases, Alliance agrees to accept the Medicare "allowable charge" as the full charge.

I understand that I am responsible for the payment of any patient liability including, but not limited to, deductibles, coinsurance or non-covered charges. Self-pay/Cash pay patients are expected to pay for services at the time services are rendered unless prior payment arrangements have been made.

I have been offered a printed copy of Alliance's Notice of Privacy Practices and I acknowledge receipt of the Patient Rights and Responsibilities and the FDA GBCA Medication Guide (if contrast is to be administered).

I have read and I understand, acknowledge and agree to the content of this General Consent form and have had my questions answered. I give my consent to receive electronic communications and survey invitations if applicable.

Patient Signature: _____ Date: _____ Time: _____

(Parent or Guardian if patient is a Minor or Incapacitated) Relationship: _____

MRI - Part B

Medical Record # / Accession #: _____

Referring Physician: _____

Ordered Exam - MRI of: _____

Facility Name: _____

Reason for Exam/Clinical Symptoms: _____

Last Name _____

First Name _____

DOB _____ **Date** _____

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

Type of Exam _____ Facility: _____ Date: _____

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

Falls risk assessment was conducted by Alliance Team Member upon first greeting the patient. TM Initials _____
Did patient pre-medicate for exam? ☐ Yes ☐ No If yes, does patient have a driver? ☐ Yes ☐ No ☐ N/A
Patient's preferred language for discussing healthcare: ☐ English ☐ Spanish ☐ Other _____

Patient's preferred survey method: ☐ Text ☐ E-mail ☐ Tablet ☐ N/A- No survey

Cell number or e-mail address: _____

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)

Barriers to Learning: ☐ Yes ☐ No	
Type	**Intervention**
☐ Language	☐ Interpreter ID# _____
☐ Hearing	☐ Repeat/Write Questions
☐ Other	☐ Family/Significant Other

Implant Investigation:

Type of Implant _____

Make _____

Model _____

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? ☐ Yes ☐ No Tech Initials _____
(Correct labeling, annotation and image quality)?

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: _____

_____

All belongings have been returned to the patient following the exam. ☐ Yes ☐ No ☐ Inpatient-N/A

Technologist Signature: _____

ALLIANCE HEALTHCARE | RADIOLOGY

Last Name _____

First Name _____

Date of Birth _____

MRI CONTRAST ADMINISTRATION RECORD

For Technologist Use Only

Has patient ever had an injection of contrast before?	☐ Yes	☐ No
Has patient ever had a previous reaction to contrast? If Yes, please explain: _____	☐ Yes	☐ No
Currently breastfeeding	☐ Yes	☐ No
History of Diabetes?	☐ Yes	☐ No
Asthma?	☐ Yes	☐ No
History of High Blood Pressure	☐ Yes	☐ No
Receiving treatment for Gout	☐ Yes	☐ No
History of breast cancer with lymph nodes removed	☐ Yes	☐ No
History of arterio-venous (AV) fistula	☐ Yes	☐ No
History of Dialysis/Kidney Failure/Renal Insufficiency (If GFR is 30 or less, also utilize Attachment A047- Informed Consent for Gadolinium in Patients with End Stage Renal Disease)	☐ Yes	☐ No

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 _____mL/s

Multi-dose vial ☐ or Single-dose vial ☐ ? If single dose vial, amount of discarded contrast _____ mL

IV Device Used _____ Time of Injection_____

Injection site evaluated prior to patient's release? ☐ Yes ☐ No
Note appearance:_____

Post Injection Instructions given ☐ Yes ☐ No

Signature of Technologist _____

Date: _____ Time: _____