

MRI Part A - RETAIL

Height _____ Weight _____ lbs/kgs

Last Name: _____

First Name: _____

DOB: _____ Date: _____

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

Last Name _____
 First Name _____
 DOB _____ Date _____

Medical Record # / Accession #: _____
 Referring Physician: _____
 Ordered Exam - MRI of: _____
 Facility Name: _____
 Reason for Exam/Clinical Symptoms: _____

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.

_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>

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

Barriers to Learning: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type	Intervention
<input type="checkbox"/> Language	<input type="checkbox"/> Interpreter ID# _____
<input type="checkbox"/> Hearing	<input type="checkbox"/> Repeat/Write Questions
<input type="checkbox"/> Other	<input type="checkbox"/> 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: _____