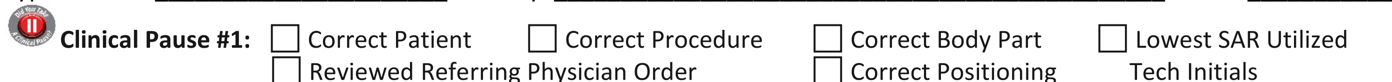
MRI - Part B

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 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. Oxygen: Flow Rate__________Liters/Minute Cylinder Pressure__________PSI

______________ ☐	______________ ☐	______________ ☐
______________ ☐	______________ ☐	______________ ☐
______________ ☐	______________ ☐	______________ ☐

☐ 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: ______________________

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

Technologist Signature: ______________________