

# North Texas Hospital

## MRI SCREENING

Date of Exam: _____ Time of Exam: _____	Exam Ordered: _____
Patient Name: _____	Date of Birth: _____
Patient Address: _____	Weight: _____ Height: _____
City: _____ State: _____ Zip: _____	Referring Physician/Specialty: _____
Phone Number: _____	Medical Record #: _____
County: _____	Diagnosis: _____
Emergency Contact Name: _____	Phone Number: _____ (cell # if avail.) _____

### PATIENT HISTORY

**MRI CANNOT** be performed if "Yes" is answered to double asterisked (\*\*) Questions.

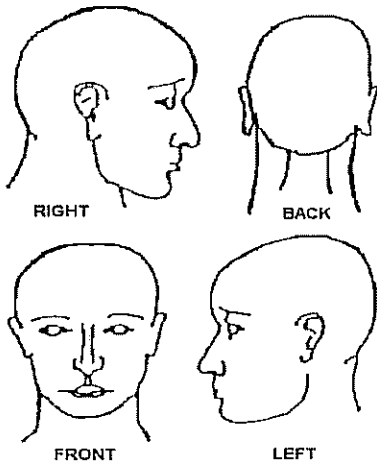
All "Yes" single asterisked (\*) are to be referred to the radiologist. For an all inclusive list of contraindications visit [mrisafety.com](http://mrisafety.com).

<p>** Pacemaker or Pacemaker wires    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Aneurysm clips    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Heart Stents    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Artificial Heart Valves    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p>* Non Removable Hearing Aid    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Metallic Foreign Body    <input type="checkbox"/> Yes    <input type="checkbox"/> No  <small>(Gun shot wounds, metal shavings in eye, retinal buckle, Have you ever worked with metal, welding, grinding?, etc.)</small></p>	
<p>If yes to previous two questions need - Date: _____ Make: _____ Model: _____</p>		
<p>Irregular Heartbeat    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Surgical or **Carotid Clips    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Infusion Pump (Implanted)    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Vena Cava (umbrella) Filter    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Allergies to IV dye, seafood, shellfish    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Diabetes    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Latex Allergies    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>History of Cancer    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Metallic Implant/Prosthesis    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Orthopedic Devices    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Wound Dressing (i.e. Acticoat 7)    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>** Small Bowel Endoscopy Capsule    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Electrodes/Neurostimulators (Tens-unit)    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p>* Pregnant / Breast Feeding    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Prior Ear or Brain Surgery    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Epilepsy (Seizures)    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Uncooperative or Disoriented    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Claustrophobia    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Unable to Hold Still    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Braces    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Removable Dental Work    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Glitter Eye Makeup    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Tattoos and/or Body Piercing    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Skin Patches    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	

(Nitroglycerine, stop smoking, pain, birth control, etc.)  
 Orbits/ X-ray cleared by \_\_\_\_\_

Please list previous surgeries \_\_\_\_\_

**Check Box below if previous scan completed was similar to body part being examined today**



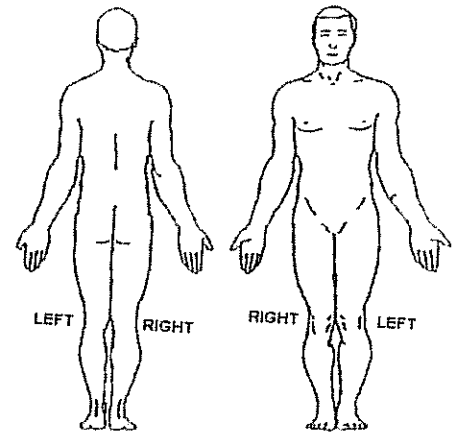
Previous MRI	<input type="checkbox"/> Yes
Previous CT	<input type="checkbox"/> Yes
Previous PET/PETCT	<input type="checkbox"/> Yes
Previous X-Rays	<input type="checkbox"/> Yes

**If yes Specify Area**

\_\_\_\_\_

\_\_\_\_\_

Using the figures, please shade in the areas affected by pain and/or numbness.



Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Exam: \_\_\_\_\_

\_\_\_\_\_

# North Texas Hospital

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

Med. Rec. #: \_\_\_\_\_

## 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.

I have read and understand the above information, and have had my questions answered. I agree to have the MRI procedure and injection of contrast if deemed necessary.

History of previous reaction  Yes  No

If Yes, Explain \_\_\_\_\_

Patient Weight: \_\_\_\_\_

Name of Contrast \_\_\_\_\_ Lot \_\_\_\_\_

Amount \_\_\_\_\_ Exp. Date \_\_\_\_\_

Injection Site: \_\_\_\_\_

Injected By: \_\_\_\_\_

Date: \_\_\_\_\_

## Signature of Patient (Parent or Guardian)

Tech Comments: \_\_\_\_\_

### Pain Screening for Verbal Patients

Is the patient having pain **before** the exam?

Yes  No

If Yes, Intervention method used for comfort:

(circle) A B C D E F G \_\_\_\_\_

Is the patient experiencing discomfort **during** the exam?

Yes  No

If Yes, Intervention method used for comfort:

(circle) A B C D E F G \_\_\_\_\_

Was the patient's pain and/or discomfort increased **after** the exam?

Yes  No

If yes, instruct patient to contact their physician.

Are you allergic to any medications, seafood, or shellfish?

Yes  No If Yes, please list:

1 \_\_\_\_\_ 4 \_\_\_\_\_

2 \_\_\_\_\_ 5 \_\_\_\_\_

3 \_\_\_\_\_ 6 \_\_\_\_\_

Has patient taken any type of medication prior to the exam?  Yes  No

List the medication(s) the patient has taken and all medications patient is currently on.

1 \_\_\_\_\_ 6 \_\_\_\_\_

2 \_\_\_\_\_ 7 \_\_\_\_\_

3 \_\_\_\_\_ 8 \_\_\_\_\_

4 \_\_\_\_\_ 9 \_\_\_\_\_

5 \_\_\_\_\_ 10 \_\_\_\_\_

Patient unaware of current medications

Prior to release patient was assessed and found impaired?  Yes  No If yes, Medical Director notified?  Yes  No  
If pt. refuses further assessment, notify Medical Director and Alliance personnel to follow policy #5023.

### MINOR MODIFICATIONS BY RADIOLOGIST/PHYSICIAN

Original Exam Order Changed to: \_\_\_\_\_ Changed by: \_\_\_\_\_ Date / Time: \_\_\_\_\_

Tech Signature: \_\_\_\_\_

Read Back  Physician Signature: \_\_\_\_\_

Discharge Instructions given (applicable to all patients who receive an injection)

Interviewer (Print) \_\_\_\_\_

Rev 2/23/06

### Pain Screening for Non-Verbal Patients

Does the patient have facial expressions or activities that would indicate the patient is having pain **before** the exam?

Yes  No

If Yes, Intervention method used for comfort:

(circle) A B C D E F G \_\_\_\_\_

Is the patient experiencing discomfort **during** the exam?

Yes  No

If Yes, Intervention method used for comfort:

(circle) A B C D E F G \_\_\_\_\_

Was the patient's pain and/or discomfort increased **after** the exam?

Yes  No

If yes, notify a member of the Health Care Team.

#### Intervention Method Used:

- A. Cushion(s)
- B. Pillow(s)
- C. Talked pt. through exam
- D. Blanket
- E. Modified exam time
- F. Consulted radiologist
- G. Other