UNIVERSITY OF VIRGINIA HEALTH SYSTEM

0300004

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

DOWNTIME RADIOLOGY MRI SCREENING SHEET

Date: _____ Sex: ☐Male ☐Female Age/Date of Birth: _____

INPATIENTS/ED: Fax form to: 4-2544	**OUTPATIENTS:** before scheduling patient for exam, fax form to: Radiology Resource Scheduling desk at 434-243-6999 OR UVA Imaging at 434-243-0307

Read the information below to the patient and ask them ALL questions and/or complete information from the Medical Record or someone else with direct knowledge of the patient. Give handout PE XXXXX to the patient/family to help them understand the information and questions.

WARNINGS AND IMPORTANT INSTRUCTIONS

- The magnet is **always on** in an MRI.
- Certain implants and devices may be unsafe to you and/or may interfere with the MR procedure.
- Generally pacemakers are contraindicated. Some types may be scanned under very restricted conditions. The presence of a pacemaker may limit the region of the body that can be scanned.
- Do not enter the MR room if you have doubts about any of the questions in this handout.
- Before entering the MR room you must remove **all metallic objects** including: hearing aids, dentures, partial plates, keys, pager, cell phone, hairpins, jewelry, body piercing jewelry, watch, safety pins, credit cards, (any card with a magnetic strip), pocket knife, nail clippers, and tools.
- Always talk with the MR technologist BEFORE entering the MR room.
- **NOTE:** You may be asked to wear earplugs or other hearing protection during the MR procedure to prevent possible noise problems.

QUESTIONS -

Are you allergic to anything? ☐ YES ☐ NO If yes, what? _____
Have you ever had any surgery before? ☐ YES ☐ NO If yes, what/when? _____
Have you ever had an MRI before? ☐ YES ☐ NO Do you have Claustrophobia? ☐ YES ☐ NO
Did you experience any problem with your prior MRI? ☐ YES ☐ NO
Have you ever had contrast (dye) for an x-ray, CT, MRI or other imaging test? ☐ YES ☐ NO
If Yes, did you have any discomfort, ill effects, or allergic reaction? ☐ YES ☐ NO

For Women:
Is there any chance that you may be pregnant? ☐ YES ☐ NO
Last Menstrual Period Date _____ Are you breast feeding? ☐ YES ☐ NO

Do you have pain which makes it hard for you to lie on your back for 30 minutes? ☐ YES ☐ NO
Have you ever had an injury to the eye involving a metallic object or fragment? ☐ YES ☐ NO
Do you have heart disease or vascular disease? ☐ YES ☐ NO
Do you have asthma? ☐ YES ☐ NO
Do you have multiple myeloma? ☐ YES ☐ NO
Do you have sickle cell anemia? ☐ YES ☐ NO

For those over 60 years of age: *(Note: "Yes" answers require a Creatinine blood test)*
Do you take generic metformin (Glucophage, Avandamet, Glocovance, or Metaglip)? ☐ YES ☐ NO
Have you had a history of kidney disease? ☐ YES ☐ NO **Do you have diabetes?** ☐ YES ☐ NO
Are you on dialysis? ☐ YES ☐ NO **When do you go for dialysis?** _____

Most MRI's can safely be performed for patients with the following (some items may need to be removed):

☐ YES ☐ NO Trouble breathing, motion disorder or Claustrophobia
☐ YES ☐ NO Vascular access port or catheter
☐ YES ☐ NO Medication Patch (ie Nicotine, Nitro)
☐ YES ☐ NO IUD, diaphragm, or pessary
☐ YES ☐ NO Dentures or partial plates
☐ YES ☐ NO Tattoo or permanent makeup
☐ YES ☐ NO Surgical staples, clips, metallic sutures
☐ YES ☐ NO Heart valve prosthesis
☐ YES ☐ NO Artificial or prosthetic limb
☐ YES ☐ NO Joint replacement (ie hip, knee)
☐ YES ☐ NO Bone/joint pin, screw, nail, wire, plate
☐ YES ☐ NO Electronic implant or device

☐ YES ☐ NO Body piercing jewelry ☐ YES ☐ NO Radiation seeds or implants
☐ YES ☐ NO Hearing Aid ☐ YES ☐ NO Wire mesh or other implants

☐*** MR scan can most likely be done with these objects.** More information may be requested about the location in the body, type of implant/foreign body, and date acquired. **Comments/Additional Information:**
☐ YES ☐ NO Any type of prosthesis (eye, penile, etc)*
☐ YES ☐ NO Eyelid spring or wire*
☐ YES ☐ NO Metallic stent, filter, coil*
☐ YES ☐ NO Any metallic fragment or foreign body*

☐**** These items may or may not be MR conditional.** Information on the make, model, and date of implant must be supplied. These items are addressed on a case by case basis and a determination made as to the safety of proceeding with the exam. In some instances it may be safe to proceed but with limitations as to the body part scanned and type of scan parameters used. The presence of these items may compromise the diagnostic quality of the exam if in the region of interest.
Comments/Additional Information:
☐ YES ☐ NO Aneurysm Clip(s)**
☐ YES ☐ NO ICP Bolt**
☐ YES ☐ NO Magnetically-activated implant or device**
☐ YES ☐ NO Neurostimulation system (DBS, Vagus Nerve)**
☐ YES ☐ NO Spinal Cord Stimulator**
☐ YES ☐ NO Internal electrodes or wires**
☐ YES ☐ NO Bone growth/Bone fusion stimulator**
☐ YES ☐ NO Cochlear, otologic, or other ear implant**
☐ YES ☐ NO Insulin or other infusion pump**
☐ YES ☐ NO Implanted drug infusion device**
☐ YES ☐ NO Shunt (spinal or ventricular)**
☐ YES ☐ NO Tissue expander (e.g. breast)**

☐***** These items are contraindicated for MRI. The MR exam will be cancelled until/unless these items are removed from the patient. Comments/Additional Information:**
☐ YES ☐ NO Cardiac Pacemaker***
☐ YES ☐ NO Implanted Cardioverter defibrillator (ICD)***
☐ YES ☐ NO Swan-Ganz or thermodilution catheter***

All warnings were read to patient/surrogate. All questions above answered. Patient/surrogate provided opportunity to ask questions. Information obtained from (check all that apply):
☐Patient ☐Nurse ☐Medical Record ☐Other _____
Name/Relationship to Patient

If translated – Interpreter Name/Cyracom ID _____
Reviewed by: Staff name/role _____Date _____Time _____
Pertinent Lab values: Creatinine_____ Creatinine Clearance/GFR: _____
☐No labs available Source: _____ Date: _____ (labs must be within 90 days of MRI)

Inpatient RN Prep Checklist

Hairpins and hair clips removed. (For head/neck MRI dentures and makeup removed).	☐ YES	☐ NO	☐ N/A
Valuables left on unit. Patient in gown without snaps	☐ YES	☐ NO	
Is patient on strict I&O?	☐ YES	☐ NO	
Rectal temperature probes removed	☐ YES	☐ NO	☐ N/A
Does pt have Holter monitor, ECG leads or patches?	☐ YES	☐ NO	
Does pt have IVAC or other infusion pump	☐ YES	☐ NO	
If yes, can IV be stopped for the duration of the MR?	☐ YES	☐ NO	
If no, (can not be stopped, 20 ft of extension tubing added between the IVAC and pt	☐ YES	☐ NO	

If preexisting IV line, line flushed by: _____
Form completed by: Nurse Name/Signature: _____ Date _____Time _____

For this exam:
Radiologist Protocol:_____ Radiologist Name _____ PIC_____
☐No changes required ☐Exceptions reviewed and protocol changed to: _____
Radiologist revising protocol – Name/PIC _____

Venipuncture Information: **Note Name and Signature/PIC or all staff:**
Date: _____ Time: _____ Site: _____ # Sticks: _____
Type needle/cathether: _____ Performed by: _____ Injection rate: _____
Contrast type: _____ Amount of contrast: _____ Lot #:_____
Injection performed by: _____ IV discontinued by: _____
Type of line accessed: _____ Color of Port Accessed: _____
Flushed with 20 ml sterile saline ☐ YES ☐ NO Name of RN notified for Heparin flush:_____
Form reviewed by:_____ Date _____Time _____
Name/Signature or PIC ☐MRI Technologist ☐Radiologist ☐Other: