



1300003

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

RADIOLOGY MRI- MRI SCREENING SHEET

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Medical Record Number: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  Male  Female

Inpatients: Fax this form to 4-2544  
Outpatients: This form should be faxed to the resource scheduling desk at (434-243-6999 UVa Main Radiology) or (434-243-0307 UVa Imaging) prior to scheduling your patient for their exam.

Radiologist protocol for this exam: \_\_\_\_\_

Radiologist: \_\_\_\_\_ PIC \_\_\_\_\_

Have you ever had any surgery before? (if yes describe below)  YES  NO  
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  
Do you have considerable pain which would make it difficult 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  
Have you ever had contrast material (dye) for a kidney x-ray, CT, MRI or other imaging test/study?  YES  NO  
If Yes, did you have any discomfort, ill effects, or allergic reaction?  YES  NO  
Is there any chance that you may be pregnant?  YES  NO LMP: \_\_\_\_\_  
Do you have heart disease or vascular disease?  YES  NO Are you breast feeding?  YES  NO  
Do you have asthma?  YES  NO Do you have multiple myeloma?  YES  NO  
Are you allergic to anything?  YES  NO Do you have sickle cell anemia?  YES  NO

\*\*\*\* If you are over 60 years of age or answer yes to any of the following question you must have a recent Creatinine. \*\*\*\*

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? \_\_\_\_\_

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

Information obtained from:  Patient  Medical Record  Family  Interpreter Signature  
Information obtained by: (print name) \_\_\_\_\_ Date: \_\_\_\_\_

PERTINENT LAB VALUES: CREATININE \_\_\_\_\_ Creatinine Clearance\ GFR: \_\_\_\_\_

No Labs Available  SOURCE: \_\_\_\_\_ DATE: \_\_\_\_\_ (labs must be within 90 days of the exam)  
Contrast screening deferred for the following reason: \_\_\_\_\_  
No changes required:  Exceptions Reviewed and protocol changed to: \_\_\_\_\_  
Radiologist revising protocol: \_\_\_\_\_ PIC: \_\_\_\_\_

VENIPUNCTURE INFORMATION Pre-existing IV  Flushed by: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Venipuncture Site: \_\_\_\_\_ # Sticks: \_\_\_\_\_  
Type needle/ cath: \_\_\_\_\_ 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 20ml's Sterile Saline:  YES /  NO Name of Nurse Notified for Heparin Flush: \_\_\_\_\_

PATIENT / FAMILY EDUCATION:  YES /  NO \_\_\_\_\_

Technologist / Nurse Signature: (print name) \_\_\_\_\_

Next Page Please

To be completed by nurse

To be completed by patient/ nurse/ caregiver

To be completed by technologist



### WARNINGS AND IMPORTANT INSTRUCTIONS

#### !!MAGNET IS ALWAYS ON!!

Certain implants and devices may be hazardous to you and/or may interfere with the MR procedure. Do not enter The MR system room if you have any questions regarding an implant, device, or object. Before entering the MR environment 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. Consult the MR technologist BEFORE entering the MR system room!

#### Please indicate if you have any of the following:

- YES  NO Aneurysm Clip(s)\*\*
- YES  NO Cardiac Pacemaker\*\*\*
- YES  NO Implanted Cardioverter defibrillator (ICD)\*\*\*
- YES  NO ICP Bolt\*\*
- YES  NO Electronic implant or device
- 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 Any type of prosthesis (eye, penile, etc)\*
- YES  NO Heart valve prosthesis
- YES  NO Eyelid spring or wire\*
- YES  NO Artificial or prosthetic limb
- YES  NO Metallic stent, filter, coil\*
- YES  NO Shunt (spinal or ventricular)\*\*
- YES  NO Vascular access port or catheter - Type \_\_\_\_\_
- YES  NO Radiation seeds or implants
- YES  NO Swan-Ganz or thermodilution catheter\*\*\*
- YES  NO Medication Patch (Nicotine, Nitroglycerine)
- YES  NO Any metallic fragment or foreign body\*
- YES  NO Wire mesh implant
- YES  NO Tissue expander (e.g. breast)\*\*
- YES  NO Surgical staples, clips, or metallic sutures
- YES  NO Joint replacement (hip, knee, etc.)
- YES  NO Bone/joint pin (screw, nail, wire, plate, etc.)
- YES  NO IUD, diaphragm, or pessary
- YES  NO Dentures or partial plates
- YES  NO Tattoo or permanent makeup
- YES  NO Body piercing jewelry
- YES  NO Hearing Aid
- YES  NO Other implant \_\_\_\_\_
- YES  NO Breathing difficulties or motion disorder
- YES  NO Claustrophobia

To be Completed by patient/ nurse/ caregiver

#### NURSING PREP LIST - INPATIENTS

1. Please send patient's chart
  2. Remove hairpins and hair clips. Dentures, and makeup need removal from head/neck exams.
  3. Keep all pt's valuables on unit (watches, jewelry etc.)
  4. Please send pt. in gown without snaps
  5. Rectal temperature probes are contraindicated for MRI and must be removed.
  6. Is patient on strict I&O?  YES  NO
  7. Does that patient have a Halter monitor, ECG leads or patches  YES  NO
  8. Does the pt. have an IVAC or other infusion pump?  YES  NO
  9. If so, can IV be removed for the duration of the MR exam?  YES  NO
- If IVAC cannot be stopped for the duration of the MR Exam, 20 ft of extension tubing must be added Between the IVAC and the patient.

\* - MR scan can most likely be performed with these objects. Additional information may be requested regarding location in the body, type of implant/foreign body, and date acquired.

\*\* - 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.

\*\*\* - These items are contraindicated for MRI. The MR exam will be cancelled until/unless these items are removed from the patient.

Please list make, model, and date of implantation for all objects marked \*\* here:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.**

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have been given the opportunity to ask questions regarding the information on this form and regarding the MR procedure I am about to undergo.

Signature of person completing form \_\_\_\_\_ Date \_\_\_\_\_

Form Completed By:  Patient  Relative  Nurse \_\_\_\_\_  
Print Name Relationship to Patient

Form Reviewed by: \_\_\_\_\_  
Print Name Signature

MRI Technologist  Radiologist  Other \_\_\_\_\_