MRI - Part A

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.

Question		
Medical/Dental procedures in the past 24 hours?	☐ YES	☐ NO
LVAD heart pump, pacemaker or pacer wires, defibrillator?	☐ YES	☐ NO
Implanted neurostimulator or TENS unit?	☐ YES	☐ NO
Medication injection device (OnPro) or pump?	☐ YES	☐ NO
Artificial heart valves/stents or aneurysm/vascular clips/grafts/shunts?	☐ YES	☐ NO
Breast tissue expander, metallic foreign body, bullet/shrapnel or any eye injury involving metal?	☐ YES	☐ NO
Small bowel endoscopy capsule or Vena Cava umbrella filter?	☐ YES	☐ NO
Recent colonoscopy or digestive system procedure involving surgical clips?	☐ YES	☐ NO
Catheter drainage tube or temperature monitor?	☐ YES	☐ NO
Prior ear, eye, or brain surgery?	☐ YES	☐ NO
List previous surgeries and their dates:	☐ YES	☐ NO
Hearing aids or Medication skin patches?	☐ YES	☐ NO
Pregnant? LMP:	☐ YES	☐ NO
Joint Replacement or orthopedic/prosthetic device?	☐ YES	☐ NO
History of Cancer? If yes, what type :	☐ YES	☐ NO
Hair extensions/wig, braces, oral springs, removable dental work, or anything held with magnets (including magnetic eyelashes) or pins?	☐ YES	☐ NO
Tattoos/Body Piercings, Glitter/permanent makeup?	☐ YES	☐ NO
DriWeave, Dri Fit, or wicking clothing?	☐ YES	☐ NO
Iron deficiency being treated with Feraheme?	☐ YES	☐ NO
History of seizures or any recent falls? If yes, when?	☐ YES	☐ NO
Diarrhea in past 2-3 days?	☐ YES	☐ NO
Claustrophobia?	☐ YES	☐ NO
Anything in or on your body that you weren't born with?	☐ YES	☐ NO

GENERAL CONSENT/ACKNOWLEDGMENT

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 acknowledge receipt of 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 ______________

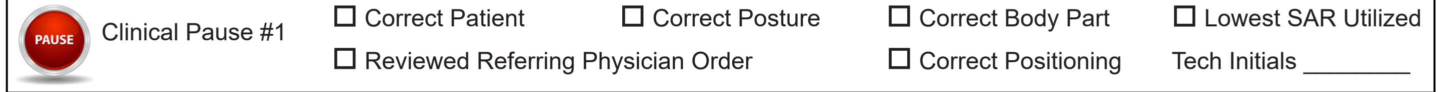
(Parent or Guardian if patient is a Minor or Incapacitated) Relationship: ______________________________

MRI - Part B

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

Last Name ______________________
First Name ______________________
DOB __________ Date __________

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 Posture ☐ 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 ☐ email ☐ Tablet ☐ N/A-No Survey
Cell number or email 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.

Medication	Taken today	Medication	Taken today	Medication	Taken today
__________	☐	__________	☐	__________	☐
__________	☐	__________	☐	__________	☐
__________	☐	__________	☐	__________	☐

☐ Patient unaware of current medications ☐ Patient Not on any medications ☐ Medical list attached (includes Name and DOB)

Barriers to Learning: ☐ Yes ☐ No

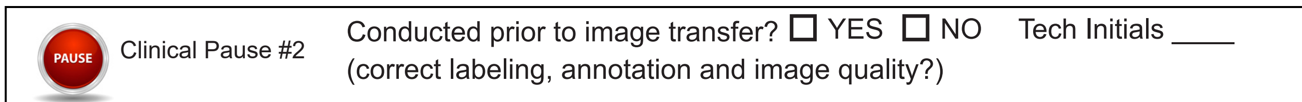
Type	Intervention
☐ Language	☐ Interpreter ID# __________
☐ Hearing	☐ Repeat/Write Questions
☐ Other	☐ Family/Significant Other

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: ______________________

____

All belongings have been returned to the patient following the exam. ☐ YES ☐ NO ☐ Inpatient - N/A
Technologist Signature: ______________________