MRI Patient Screening Form

MRI SERVICES PATIENT INFORMATION

Patient Name:_____ Exam Ordered:_____

Date of Birth: _____ Physician:_____

Patient Stated Weight:_____ ICD-10 Code:_____

Emergency Contact Name/Phone Number: _____

PATIENT HISTORY

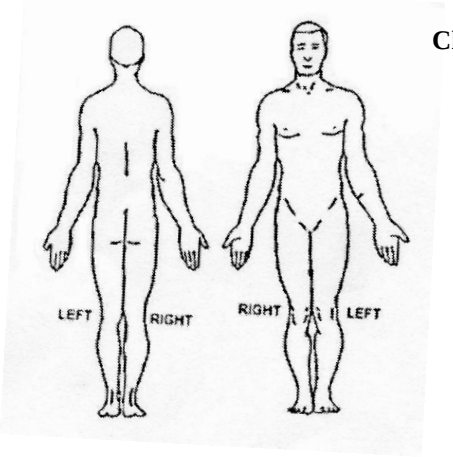
MRI CANNOT be performed **if "Yes"** is answered to triple asterisked (***) questions.
Double asterisked (**) require a signed contraindication release. Single asterisked (*) must be referred to radiologist.

***	**Pacemaker or Pacemaker wires**	☐ Yes ☐ No	*	**Diabetes (Diabetic Pump)**	☐ Yes ☐ No
***	**Small Bowel Endoscopy Capsule**	☐ Yes ☐ No	*	**Wound Dressing (i.e. Acticoat 7)**	☐ Yes ☐ No
**	**Pregnant / Breast Feeding**	☐ Yes ☐ No	*	**Breast Tissue Expanders**	☐ Yes ☐ No
	Asthma	☐ Yes ☐ No		**Irregular Heartbeat**	☐ Yes ☐ No
*	**Carotid Clips**	☐ Yes ☐ No		**Electrodes/Neurostimulators (Tens-unit)**	☐ Yes ☐ No
*	**Artificial Heart Valves**	☐ Yes ☐ No		**Vena Cava Umbrella Filter**	☐ Yes ☐ No
*	**Heart Stents**	☐ Yes ☐ No		**Latex Allergies**	☐ Yes ☐ No
	If yes to previous two questions, need -			**History of Cancer _____**	☐ Yes ☐ No
	Date:_____ Make:_____			**Metallic Implant/Prosthesis/Orthopedic Devices**	☐ Yes ☐ No
	Model:_____			**Removable Hearing Aid**	☐ Yes ☐ No
*	**History of severe hepatic disease/liver transplant/pending liver transplant** (no contrast for perioperative liver pts.)	☐ Yes ☐ No		**Epilepsy (Seizures)**	☐ Yes ☐ No
				Uncooperative or Disoriented	☐ Yes ☐ No
*	**Hypertension**	☐ Yes ☐ No		**Claustrophobic**	☐ Yes ☐ No
*	**Aneurysm/Vascular Clips/Grafts/Stents/Repair**	☐ Yes ☐ No		**Unable to Hold Still**	☐ Yes ☐ No
*	**Surgical Clips**	☐ Yes ☐ No		**Braces**	☐ Yes ☐ No
*	**Infusion Pump**	☐ Yes ☐ No		**Removable Dental Work**	☐ Yes ☐ No
*	**Allergies to IV dye, seafood, shellfish**	☐ Yes ☐ No			
*	**Dialysis/Renal Failure/Renal Insufficiency**	☐ Yes ☐ No		**Tattoos and/or Body Piercing**	☐ Yes ☐ No
*	**Metallic Foreign Body** (Gun shot wounds, metal shavings in eye, retinal buckle, etc.)	☐ Yes ☐ No		**Medication Skin Patches** (Nitroglycerine, stop smoking, pain, birth control, etc.)	☐ Yes ☐ No
*	**Prior Ear or Brain Surgery**	☐ Yes ☐ No		**Need Screening Orbits/X-ray**	☐ Yes ☐ No
				Any history with a * or ** approved by radiologist/nephrologist	☐ Yes ☐ No **If no, explain:**

Please list all previous surgeries:_____

_____ _____

_____ _____



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

Previous MRI	☐ Yes
Previous CT	☐ Yes
Previous PET/PETCT	☐ Yes
Previous X-Rays	☐ Yes

If yes, Specify Area

_____

_____

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

Insurance:_____ ICD-10 Code:_____

Does Insurance Require Preauthorization?_____ Authorization #:_____

Patient Signature:_____ Date:_____

RADIOLOGY ORDER FORM

Scheduled For:_____

Forks Community Hospital 530 Bogachiel Way, Forks, WA 98331 360-374-6271 x166 Fax 360-374-6084

Patient _____**Date of Birth** _____**Patient Phone**_____

Provider Signature _____**Date**_____ **CT/MRI Authorization #:**_____

Instructions: ☐ Cc Report to:_____ ☐ Call Report ASAP ☐ Call Patient to Schedule Appt

CLINICAL HISTORY/INDICATIONS:_____

_____

X-RAY

☐ Abdomen 1 view-KUB-supine
☐ Abdomen 2 view-upright/supine
☐ Abdomen 3 view-includes CXR
☐ Chest PA & Lateral
☐ Ribs w/ PA Chest (L) (R)
☐ Sternum
☐ Pelvis

SPINE

☐ Cervical Spine-AP,Lat,Odontoid
☐ Cervical Spine w/ Obliques
☐ Cervical w/ Flexion /Extension
☐ Soft Tissue Neck
☐ Thoracic Spine
☐ Lumbar Spine (AP, Lat, Spot)
☐ Lumbar Spine w/ Obliques
☐ Sacrum/Coccyx
☐ Sacroiliac (SI) Joints B/L

UPPER EXTREMITY

☐ Finger / Thumb (L) (R)
☐ Hand (L) (R)
☐ Wrist (L) (R)
☐ Forearm (L) (R)
☐ Elbow (L) (R)
☐ Humerus (L) (R)
☐ Shoulder (L) (R)
☐ Acromioclavicular (AC) Joints
☐ Clavicle (L) (R)
☐ Scapula (L) (R)

LOWER EXTREMITY

☐ Toe(s) (L) (R)
☐ Foot (L) (R)
☐ Calcaneus (L) (R)
☐ Ankle (L) (R)
☐ Tibia/Fibula (lower leg) (L) (R)
☐ Knee (L) (R)
☐ Femur (L) (R)
☐ Hip includes Pelvis (L) (R)

HEAD

☐ Nasal Bones
☐ Orbits for MRI Screening

FLUORO

☐ Esophagram (Barium Swallow)
☐ Upper GI
☐ Small Bowel Follow Through
☐ Barium Enema

DXA- BONE DENSITY

☐ DXA-Bone Density

Prior Exam Date:_____

ULTRASOUND

☐ Abdominal Complete
☐ Abdominal Limited-single organ
☐ Aorta
☐ Arterial Lower Ext (L) (R)
(including Iliacs/Aorta & ABI's pre/post)
☐ Breast (L) (R)
☐ Cardiac Echo
☐ Carotid (Bilateral)
☐ Chest or Pleural Fluid
☐ Extremity (Non-Vascular)
☐ OB < 14 wks + Transvaginal PRN
☐ OB > 14 wks + Transvaginal PRN
☐ OB Biophysical Profile/Umbilical Art
☐ Pelvic TransAbd &/or Transvaginal
☐ Renal
☐ Renal w/ Bladder pre/post Void
☐ Bladder pre/post Void
☐ Scrotum / Testicle
☐ Soft Tissue Neck
☐ Thyroid
☐ Venous (L) (R) _____

MAMMOGRAPHY

☐ Annual Screening
☐ Unilateral Left
☐ Unilateral Right
☐ Diagnostic Bilateral

CT

Specify Contrast for Exam:

☐ As Medically Indicated
☐ With IV Contrast ☐ No IV Contrast
☐ With & w/out IV Contrast
☐ Oral Contrast ☐ Rectal Contrast

Creatinine_____BUN_____

Date Drawn: _____

(within 30 days of scan)

☐ **Lab Order: Creatinine & BUN**

ICD9 Code_____(required for Lab)

☐ Chest ☐ Abd / Pelvis
☐ Abdomen ☐ Pelvis
☐ KUB (kidney stone) w/o contrast
☐ Renal Protocol w/ IV contrast

SPINE

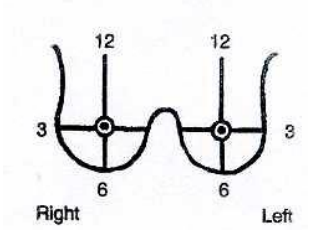
☐ Cervical Spine
☐ Thoracic Spine, Level:_____
☐ Lumbar Spine
☐ Sacrum / Coccyx

HEAD / NECK

☐ Head
☐ Sinuses
☐ Facial Bones
☐ Temporolmandibular TMJ Joints
☐ IAC / Temporal Bones
☐ Soft Tissue Neck

EXTREMITIES

☐ Extremity (L) (R)
Specify Location: _____



MRI

Complete Screening Form on Back

Specify Contrast for Exam:

☐ As Medically Indicated
☐ W/ IV Contrast ☐ No IV Contrast
☐ With & w/out IV Contrast

Creatinine:_____BUN:_____

GFR: _____

Date Drawn: _____

(within 30 days of scan)

*Required for ALL contrast patients

☐ **Lab Order: Creatinine**

ICD9 Code_____(required for Lab)

UPPER EXTREMITY

☐ **Left** ☐ **Right**

☐ Shoulder ☐ Humerus ☐ Elbow
☐ Forearm ☐ Wrist ☐ Hand

LOWER EXTREMITY

☐ **Left** ☐ **Right**

☐ Hip ☐ Femur ☐ Knee
☐ Tibia / Fibula ☐ Ankle ☐ Foot

SPINE

☐ Cervical Spine ☐ Thoracic Spine
☐ Lumbar Spine ☐ Sacrum / Coccyx
☐ Sacroiliac (SI) Joints

HEAD / NECK

☐ Brain ☐ Facial Bones ☐ Pituitary
☐ Temporal Bone / IAC
☐ Temporomandibular TMJ Joints
☐ Soft Tissue Neck ☐ Sella/IAC

OTHER

☐ Chest ☐ Abdomen ☐ Pelvis ☐ Aorta

Any Other Procedure:

_____

_____