Northeast Radiology

Mammography, Breast US and Breast MRI Questionnaire

REFERRING MD _____
PRIMARY CARE MD _____

NAME _____ AGE _____
DATE _____ DOB _____ LAST MENSTRUAL PERIOD _____

DATE OF LAST FULL BREAST PHYSICAL EXAMINATION BY A DOCTOR: _____

Female patients: Are you currently pregnant? ◯ Y / N ◯

Reason for Mammogram / Breast US / Breast MRI

Routine ☐ Abnormal Mammogram / US ☐

When did symptoms first occur?

Lump (new or enlarging)	☐ R / L ☐	_____
Nipple discharge	☐ R / L ☐	_____
Pain / soreness	☐ R / L ☐	_____
Other	☐ R / L ☐	_____

History

Have you breastfed within the past six months?	☐ Yes	No ☐
Have you ever been told you have breast cancer?	☐ Yes	No ☐
Are you currently on hormone therapy (estrogen)?	☐ Yes	No ☐
Breast cancer pre-op staging	☐ R	L ☐
Breast cancer follow-up	☐ R	L ☐
Is there a history of breast cancer in your family?	☐ Yes	No ☐

If **"Yes"** please check / enter age of relative who had cancer:

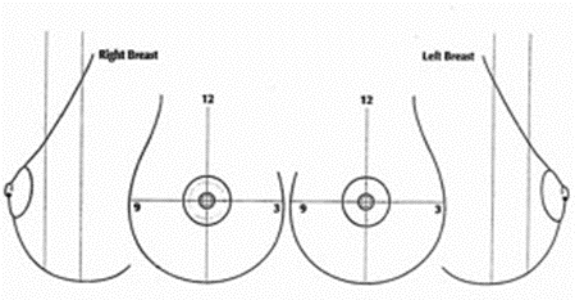
☐ Sister _____ ☐ Mother _____ ☐ Daughter _____

Previous mammograms, breast ultrasounds, or breast MRIs

Most recent _____ Where _____ What exam _____
Next most recent _____ Where _____ What exam _____

Breast Surgery: Date

Mastectomy	☐ R / L ☐	_____
Lumpectomy for cancer	☐ R / L ☐	_____
Benign surgical biopsy	☐ R / L ☐	_____
Stereotactic biopsy	☐ R / L ☐	_____
US core biopsy	☐ R / L ☐	_____
Cyst aspiration	☐ R / L ☐	_____
Implants	☐ R / L ☐	_____
Reduction	☐ R / L ☐	_____
MRI Core Biopsy	☐ R / L ☐	_____



Name of Tech: _____ Patient Signature: _____

WORKSHEET

NAME: _____DOB:_____ DATE: _____

PROCEDURE: _____ SITE_____

CLINICAL HISTORY: _____

IMPRESSION:_____

*****************STAFF USE ONLY****************

TIME OUT performed_____ AM PM Allergies Confirmed YES NO

Procedure_____Site R / L _____Tech/RN Signature_____

Radiologist_____

eGFR_____ Creatinine_____Reference Range_____-_____Date_____

Contrast/Amt_____ mL Lot#_____Exp Date_____NDC#_____S / M Disc_____mL

Injection Site R / L_____Time_____Flow Rate_____IV device_____

Gadavist + Amt_____mL Lot#_____Exp Date_____NDC#_____S / M Disc_____mL

Lidocaine 1%/Xylocaine 1% + Amt_____mL Lot#_____Exp Date_____NDC#_____S / M Disc_____mL

Xylocaine 1% w/Epi **1:100,000** + Amt_____mL Lot#_____Exp Date_____NDC#_____S / M Disc_____mL

Sodium Chloride 0.9% + Amt_____mL Lot#_____Exp Date_____NDC#_____S / M Disc_____mL

Priors: NO YES_____

Tech/RN notes?_____

_____

_____

_____

Revised 17 June 2020

MRI Safety Questionnaire

Patient Name: Weight:

DOB: Allergies: Date:

Previous Exams related to this visit:

MRI	Where:	When:	Results:
CT Scan	Where:	When:	Results:
Ultrasound	Where:	When:	Results:
Bone Scan	Where:	When:	Results:
X-Rays	Where:	When:	Results:

The following items may interfere or be potentially hazardous with an MRI examination.
Please indicate if you have any of the following:

	Yes	No		Yes	No
Cardiac Pacemaker	☐	☐	Hair Extensions	☐	☐
Heart Valve Replacement	☐	☐	Infusion/Insulin Pump	☐	☐
Heart Bypass Surgery	☐	☐	Bone Fixation Devices	☐	☐
Cerebral Aneurysm Clips	☐	☐	IUD/Pessary Ring	☐	☐
Intraventricular Shunt (Brain)	☐	☐	Artificial Limb/Joint	☐	☐
Vascular Coil, Filter, or Stent	☐	☐	Dentures	☐	☐
Stapes/Cochlear Implant (Ear)	☐	☐	Nitroglycerin Patch	☐	☐
Hearing Aid	☐	☐	Penile Prosthesis	☐	☐
Orbital Prosthesis (Eye)	☐	☐	Chance of Pregnancy LMP_____	☐	☐
Eye Lens Implant	☐	☐	Any Type of Tissue Expander	☐	☐
Neurostimulator (Tens Unit)	☐	☐	Any Personal History of Cancer	☐	☐
Optic Neuritis	☐	☐	If yes, please indicate type:		

Have you ever had an endoscopy / colonoscopy with placement clips within the last 6 weeks?

Please list all prior surgery or operations in your lifetime.

Have you ever been injured by a metallic foreign body? (Ex. Bullet, BB, Shrapnel)

Have you ever been injured in the EYE by a metallic foreign body? (Ex. metal sliver)

Do you have any kidney function problems? Diabetes? High blood pressure on medication?

Do you have any tattoos,body piercings or magnetic eyelashes?

This information is correct to the best of my knowledge. I have read and understand the purpose of this form and have had the opportunity to ask questions.

Patient Signature: _____ Technologist Signature: _____

Northeast Radiology

OUT-PATIENT FALL RISK ASSESSMENT

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ SITE NAME: _____

INTERVIEWER NAME: _____ CUSTOMER NUMBER: _____

Patient: The following questions are intended to identify patients who may be at risk of falling and to help avoid potential injury. This procedure has been implemented to ensure your safety and to enable us to provide you with the best possible patient care.

Please circle the appropriate answer to each question below. Our staff will go over these questions with you prior to your examination to address any questions or concerns you may have.

1. Have you fallen recently (within the last 3 months)?	YES	NO
2. Do you use a cane, walker or other device to help you walk?	YES	NO
3. Do you require assistance to stand up?	YES	NO
4. Have you taken any medications today for anxiety or to relax you?	YES	NO
If yes, what medication? _____ Dosage _____ Time _____		
5. Are you dizzy, lightheaded, weak in your legs or unable to see or hear clearly?	YES	NO

Team Member: If the patient, patient's family member or caregiver answers "yes" to any of the above questions, transport the patient via wheelchair to the imaging system or exam/treatment room.
All patients must be assessed for falls risk prior to transporting patients from the waiting area. The entire form must be completed signed and retained in the patient's medical record whenever a patient refuses a wheelchair.
Mobile Units Only- The top portion of this document must be completed and retained in the patient's medical record whenever a mobile units lift or roll/slide door is inoperable and the units stairs must be utilized. If any "yes" answers are provided, the patient may not utilize the mobile unit stairs and must reschedule for a time when the lift/roll/slide door is operable.

RELEASE OF LIABILITY

Notwithstanding the evaluated risk of fall and Alliance's offer/recommendation to use a wheelchair for transport to/from the imaging system or exam/treatment room, I decline the use of a wheelchair. By declining the use of wheelchair for transport to/from the imaging system or exam/treatment room, I agree, acknowledge and assume all inherent risk including but not limited to the risk of falling, personal injury, damage to personal property, or otherwise. I, on behalf of myself, heirs and/or representatives, do hereby waive and agree to release and hold harmless Alliance HealthCare Services, Inc., its officers, agents, subsidiaries and employees from any and all liability for any damage, claim or injury to myself or my property or otherwise.

PATIENT SIGNATURE: _____

WITNESS SIGNATURE: _____ TITLE: _____