Northeast Radiology

MRI Questionnaire

Name: DOB: Date:

Area to be scanned: _____

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?

_____

_____

2. Is today's visit a result of an injury? YES (answer A,B & C) NO (continue to question #3)

YES A. Where did event occur? (home, park) _____

B. When did it occur? (month, day,year) _____

C. How did it occur? (events which led to injury) _____

_____

_____

3. What complaints or symptoms caused you to seek medical help?

_____

_____

4. How long have you had these symptoms?

_____

_____

5. Did these symptoms come on suddenly or gradually?

_____

_____

6. Are these symptoms the:

☐ Same ☐ Better ☐ Worse

7. Have you had any previous surgery? ☐ Yes ☐ No

If yes, please describe: _____

8. Have you had any previous testing done for this problem? ☐ Yes ☐ No

If yes, please list all tests done:

_____

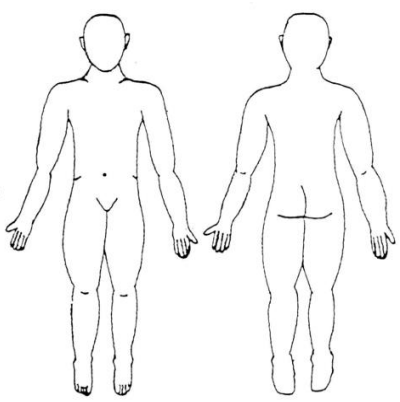
_____

BODY DIAGRAM ON BACK

(OVER)

PATIENT NAME: DOB:

PLEASE SHADE IN THE REGIONS THAT HURT



Female patients only:
Are you pregnant? ◯ Y / N ◯ Last menstrual period: _____

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

eGFR Creatinine Reference Range - Date

Gadavist + Amt mL Lot# Exp Date NDC# S / M Disc mL

Eovist + Amt mL Lot# Exp Date NDC# S / M Disc mL

Injection Site R / L Time Flow Rate IV device

GlucaGen + Amt mL Lot# Exp Date NDC# S / M Disc mL

Volumen + Amt mL Lot# Exp Date NDC# S / M Disc mL

Saline 0.9% + Amt mL Lot# Exp Date NDC# S / M Disc mL

Priors: NO YES

Tech/RN notes?

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: _____