Northeast Radiology

# HEAD/BRAIN QUESTIONNAIRE

Name: DOB: Date:

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

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

3. How long have you had these symptoms?

4. Did these symptoms come on suddenly or gradually?

5. Are these symptoms the: ☐ Same ☐ Better ☐ Worse

6. Do you have any weakness on one side of your body? ☐ Yes ☐ No

   If yes, which side? ☐ Right ☐ Left

7. Have you ever had visual problems? ☐ Yes ☐ No

   If yes, please describe:

8. Have you ever had speech problems? ☐ Yes ☐ No

   If yes, please describe:

9. Do you have hearing problems? ☐ Yes ☐ No

   If yes, which side? ☐ Right ☐ Left

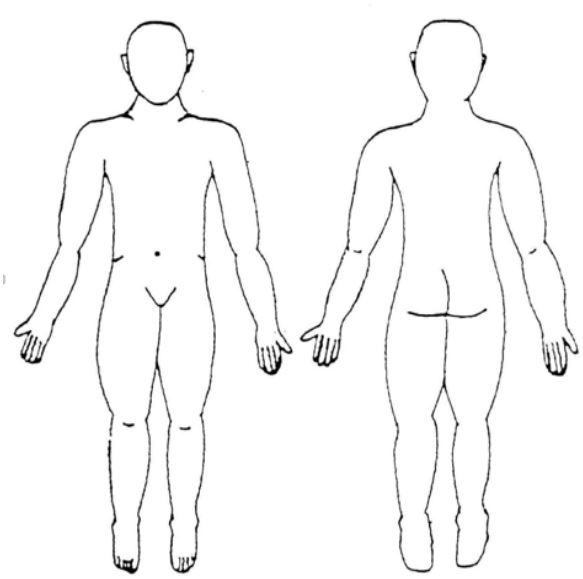
   Please describe:

10. Please check if you have any of the following:

- ☐ Balance Problems
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Old Stroke
- ☐ Heart Disease
- ☐ Sickle Cell Disease
- ☐ Cancer Type:
- ☐ Other Medical Problems:

**BODY PICTURE ON BACK**

PLEASE SHADE IN THE REGIONS THAT HURT



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

PATIENT NAME:_____DOB:_____

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

**e**GFR_____ Creatinine_____

Reference Range_____-_____Date_____

Contrast Name_____ Contrast Amount_____mL Lot#_____

Contrast Expiration Date_____ NDC#_____

Injection Site_____Flow Rate_____

Multi-dose vial ☐ or Single dose vial ☐?

If single dose, amount of discarded contrast_____ml

IV device used_____Time of Injection_____Tech/RN signature_____

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: _____

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# 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 |

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***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: _____