

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**WHICH KNEE?** **RIGHT** **LEFT**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. Is today's visit a result of an injury? YES (answer A,B &amp; 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) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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. Please check if you have any of the following:

- Knee locking
- Clicking in your knee when you walk
- Knee giving out on you
- Something moving in your knee when you walk

8. Have you ever had a prior knee injury?  Yes  No

If yes, please describe: \_\_\_\_\_

9. Have you ever had surgery on this knee?  Yes  No

- Arthroscopic
- Open Surgery
- Meniscectomy
- Ligament Repair
- Knee Replacement

When and Where: \_\_\_\_\_

When and Where: \_\_\_\_\_

When and Where: \_\_\_\_\_

When and Where: \_\_\_\_\_

When and Where: \_\_\_\_\_

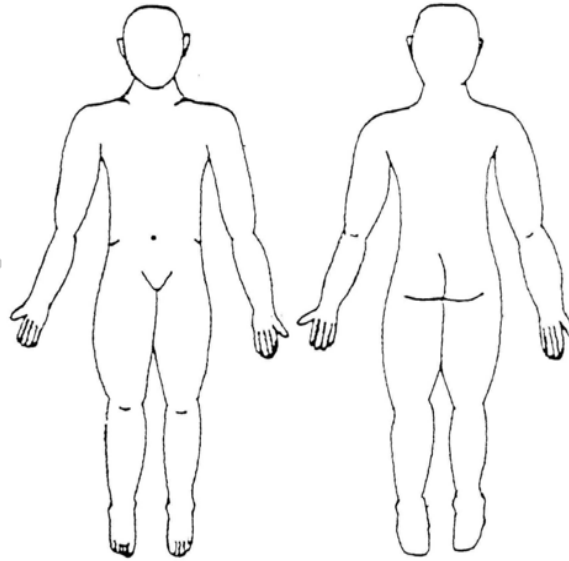
10. Have you ever had an Arthrogram on this knee?  Yes  No

If yes, when and where? \_\_\_\_\_

11. Do you have any history of cancer?  Yes  No

If yes, please describe: \_\_\_\_\_

PLEASE SHADE IN THE REGIONS THAT HURT



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

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

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

eGFR \_\_\_\_\_ 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	<input type="checkbox"/>	<input type="checkbox"/>	Hair Extensions	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Infusion/Insulin Pump	<input type="checkbox"/>	<input type="checkbox"/>
Heart Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Bone Fixation Devices	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Aneurysm Clips	<input type="checkbox"/>	<input type="checkbox"/>	IUD/Pessary Ring	<input type="checkbox"/>	<input type="checkbox"/>
Intraventricular Shunt (Brain)	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Limb/Joint	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Coil, Filter, or Stent	<input type="checkbox"/>	<input type="checkbox"/>	Dentures	<input type="checkbox"/>	<input type="checkbox"/>
Stapes/Cochlear Implant (Ear)	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin Patch	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>	Penile Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>
Orbital Prosthesis (Eye)	<input type="checkbox"/>	<input type="checkbox"/>	Chance of Pregnancy LMP _____	<input type="checkbox"/>	<input type="checkbox"/>
Eye Lens Implant	<input type="checkbox"/>	<input type="checkbox"/>	Any Type of Tissue Expander	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulator (Tens Unit)	<input type="checkbox"/>	<input type="checkbox"/>	Any Personal History of Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Optic Neuritis	<input type="checkbox"/>	<input type="checkbox"/>	<u>If yes, please indicate type:</u>		

**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: \_\_\_\_\_

EXCEL/FORMS /MRI SAFETY QUESTIONNAIRE REVISED 10/28/2019



### 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: \_\_\_\_\_