MRI Patient Screening Form - Part B

Patient Name:_____ **Date of Birth:**_____ **Date:**_____

CONTRAST

Your physician or radiologist may deem it necessary for you to have an IV injection of a contrast agent containing gadolinium to improve the quality of your MR examination. Although gadolinium contrast agents have been used safely in millions of patients, minor reactions (principally headache or nausea), and serious or life threatening reactions may occur.

I have read and understand the above information, and have had my questions answered. I agree to have the MRI procedure with injection of contrast if deemed necessary.

History of previous reaction ❑ Yes ❑ No

If Yes, Explain _____

Patient Stated Weight _____

eGFR _____ (Range: Low = 30 High = > 60)

_____ Date: _____

Signature of Patient (Parent or Guardian if patient is a Minor or Incapacitated)

Contrast Name _____

Amount _____

Lot # _____

Exp. Date _____

Injection Site _____

Device Used _____

Rate of Admin. _____

Tech Initials _____

Post Injection Check: Time:_____ Has patient's condition changed since injection? No _____ Yes _____

If Yes, specify change: _____

Are you allergic to any medications, seafood, or shellfish?

❑ Yes ❑ No If Yes, please list:

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

❑ Patient unaware of current medications

❑ Patient not on any medications

Barriers to Learning ❑ Yes ❑ No

Type:	Intervention:
❑ Language	❑ Interpreter Used
❑ Hearing	❑ Repeat Questions
❑ Other	❑ Family/Significant Other

List any medication(s) the patient has taken today and all current medications:

(Include over the counter, ointments, herbals, vitamins, birth control, etc.)

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

If patient has self-medicated for anxiety/claustrophobia specifically for today's procedure (not routine medications), do they have a driver? ❑ Yes ❑ No

Prior to release, patient was assessed and found impaired? ❑ Yes ❑ No If yes, Supervising Physician notified? ❑ Yes ❑ No

If patient refuses further assessment, notify Supervising Physician and Alliance personnel to follow policy #5023.

Comments:_____

MINOR MODIFICATIONS BY RADIOLOGIST/PHYSICIAN ❑ Yes ❑ No

Original Exam Order Changed to:_____ **Changed by:**_____ **Date/Time:** _____

Tech Signature: _____ **Read Back ❑ Yes ❑ No Physician Signature:** _____

Post Injection Instructions given (applicable to all patients who receive an injection).	**❑ Yes**	**❑ No**	**❑ N/A**
Patient notified of rights and opportunity to "Speak up" with questions or concerns.	**❑ Yes**	**❑ No**	
Handoff Report given to next provider of care. Medication list provided if applicable.	**❑ Yes**	**❑ No**	**❑ N/A**
Patient received ear protection.	**❑ Yes**	**❑ No**	

Team Member Signature _____

Title: _____ **Date:** _____

Tech Comments _____

_____

_____