

**OUTPATIENT MRI ORDER/PRESCREENING QUESTIONNAIRE (Please print)**

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient's Phone (8AM-4PM): \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Can we leave a message?  Yes  No  
 (If we cannot leave a message for patient,  
 please have patient call us next business day.)

**Physician Signature:** \_\_\_\_\_

Date/Time: \_\_\_\_\_

Type of MRI ordered: \_\_\_\_\_  W  WO  W/WO

Diagnosis/What are we looking for? \_\_\_\_\_

Symptomatology/Findings: \_\_\_\_\_

YES	NO	PLEASE ANSWER EACH QUESTION
		Does patient have a pacemaker (or pacemaker wires in chest) , implantable cardiovascular device (ICD) or external device (insulin pump)?
		Does patient have a brain aneurysm clip? If yes, call MRI at 747-1707 before scheduling.
		Does patient have fear of close places (claustrophobia)? If yes, physician to specify minimal or moderate sedation? <input type="checkbox"/> minimal (anxiolysis) <input type="checkbox"/> moderate
		Is patient $\geq 60$ years of age? ____ Yes ____ No Patient weight: _____ Is the patient diabetic? ____ Yes ____ No Patient height: _____ <b>If yes to either of the above a BUN and Creatinine is required (within 90 days) if patient is receiving contrast.</b> If BUN and Creatinine tests were done at RRMCM, enter date _____ If these labs were done elsewhere, fax results to 772-2545.
		Has patient ever had eye surgery that resulted in implants other than cataract lens? If yes, what/when? _____
		Has patient ever had ear surgery that resulted in a metal cochlear implant? If yes, call MRI with type of implant. _____
		Has patient ever had an accident with metal in the eye? If yes, have they had an MRI since? If not, patient must have an x-ray before the MRI (can be done 1-2 days prior or before 5 pm day of exam).
		Has patient had any recent prior surgery, as MRIs should be done 4-8 weeks after most surgery? (If the patient has had a coronary stent or Greenfield filter put in, scan must be 6 weeks postop. Date/type of recent prior surgery: _____
		Does patient have any implanted devices (other than cataract lenses)? If yes, what? _____
		Is patient pregnant or think she may be pregnant? ____ Is the patient a nursing mother? ____
		Does patient have difficulty laying flat on their back? ____ Yes ____ No

To be completed by central scheduling personnel

MRI scheduled for: \_\_\_\_\_

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

Other Exams \_\_\_\_\_

MRUN: \_\_\_\_\_

Booked by: \_\_\_\_\_

Date/Time \_\_\_\_\_