BRIGHAM AND WOMEN'S
Faulkner Hospital

MRI
Phone: 617-983-4479
Fax: 617-983-7855

MR#: ___

Patient Name: ___

DOB: ___

MRI CONFIRMATION / CHECKLIST

For Telephone Cofirmation Only:

Attempt #1: Date of call: ___ Status Code: ___ Caller Initials: ___
Attempt #2: Date of call: ___ Status Code ___ Caller Initials: ___

Status Codes: **C** = confirmed **NA** = no answer **LM** = left message **WN** = wrong number **DC** = disconnected

Please indicate if you have any of the following:

☐ Yes ☐ No **Cardiac/Heart Pacemaker, pacemaker leads?***
☐ Yes ☐ No **Implanted Cardiac Defibrillator (ICD), Cardiac Electrodes, Pacing wires, Internal Electrodes?***
☐ Yes ☐ No **Any type of Neurostimulator or Bone Growth Stimulator? ***

*** If Yes to above, cancel MRI and consider an alternative exam.**

☐ Yes ☐ No Aneurysm clip(s)?
☐ Yes ☐ No Have you swallowed a Gastroenterology pill camera?
☐ Yes ☐ No Medication patch? If yes, please remove before MRI
☐ Yes ☐ No Ear implant; Cochlear, Otologic (not referring to a hearing aid)?
☐ Yes ☐ No Tissue expander (e.g., breast)?
☐ Yes ☐ No Swan-Ganz/Thermo Dilution catheter?
☐ Yes ☐ No Recent Colonoscopy or surgery? Were clips, wires, pins, metal staples, etc. placed? ☐ Yes ☐ No
☐ Yes ☐ No Is there any possibility of pregnancy?
☐ Yes ☐ No Electronic or magnetic implant/device? **If yes, what kind?** ___
☐ Yes ☐ No Eye implant, eye prosthesis or device: i.e., eyelid spring, wire? **If yes, what kind?** ___
☐ Yes ☐ No Shunts, e.g. spinal, intraventricular, peritoneal, other? **If yes, what kind?** ___
☐ Yes ☐ No Stents or grafts, e.g. heart, kidney, carotid, endovascular, blood vessel, IVC? **If yes, what kind?** ___
☐ Yes ☐ No Do you have claustrophobia? If yes, did you pre-medicate? ☐ Yes ☐ No
☐ Yes ☐ No Implanted drug infusion pump or insulin pump? **If yes, what kind?**
☐ Yes ☐ No Worked with metal or ever had metal fragments in eye(s)?
If Yes, was it removed during a medical exam? ☐ Yes ☐ No

Patient Height: ___ **Patient Weight:** ___

☐ Yes ☐ No Metal fragments/shrapnel, bullets, metal foreign body?
☐ Yes ☐ No Heart valve prosthesis/replacement? **If yes, what kind?** ___
☐ Yes ☐ No Joint replacement (hip, knee, etc.), pins, screws, wire, plates, Harrington rods?
☐ Yes ☐ No Prosthetic or artificial limb?
☐ Yes ☐ No Wire mesh, e.g. hernia repair?
☐ Yes ☐ No Penile implant?
☐ Yes ☐ No Surgical staples, clips, metal stitches?
☐ Yes ☐ No IUD, diaphragm, or pessary?
☐ Yes ☐ No Dentures, partial plates, dental implants, hearing aid?
☐ Yes ☐ No Body piercing, tattoo, permanent make-up?
☐ Yes ☐ No Do you have a history of Cancer? Please specify: ___
☐ Yes ☐ No Have you had surgery in the area of your exam, or have you had any other surgeries?
Details: ___

Patient/Guardian/Interviewer Signature: ___ **Date:** ___ **Time:** ___

Technologist use only: PFS>

Was an x-ray performed for foreign body confirmation? ☐ **Yes** ☐ **No Clearing Radiologist**: ___

Double identifiers ☐ **Yes** ☐ **No** Allergies reviewed ☐ **Yes** ☐ **No** Injection tubing primed ☐ **Yes** ☐ **No**

Screening reviewed ☐ **Yes** ☐ **No** Labs reviewed ☐ **Yes** ☐ **No** Protocol in place and reviewed ☐ **Yes** ☐ **No**

Technologist Signature: ___ **Date:** ___ **Time:** ___

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Standard Register

Medical History Questions:

☐ Yes ☐ No Do you have any allergies? **If "Yes," please list:** ____________

☐ Yes ☐ No Have you ever had an injection for an MRI exam? **Complications?** ____________

If yes, premedicated? ☐ Yes ☐ No Type of medication? ____________

Do any of the following apply to you?

☐ Yes ☐ No Are you currently on dialysis *

☐ Yes ☐ No Kidney disease? *

☐ Yes ☐ No Family history of kidney failure (polycystic kidneys)? * ____________

☐ Yes ☐ No Lupus? *

☐ Yes ☐ No Diabetes? *

☐ Yes ☐ No Multiple Myeloma? *

☐ Yes ☐ No Chronic Liver Disease? *

☐ Yes ☐ No *Pre or Post liver transplantation?* *

* ***If "Yes," labs for Creatinine must be drawn within 3 weeks of scheduled appointment.***

Please document if patient had recent lab work performed. Where? ____________ **When?** ____________

Current Medication Questions:

Instruction: Patient should bring a list of current medications on the day of exam.

Current Medications: ____________

☐ Yes ☐ No Do you take any nonsteroidal anti-inflammatory drugs (NSAIDS) on a regular basis? *
For example: Aleve/Anaprox; Naprosyn (Naproxen); Celebrex (celecoxib); Motrin/Advil (ibuprofen); Indocin?

**** If "Yes," to above:***

☐ Yes ☐ No Will you be taking this/these medication(s) for 4 consecutive days prior to your exam?

Have you taken any of the following antibiotics intravenously for 2 or more days within the last 7 days? **

☐ Yes ☐ No Amikacin

☐ Yes ☐ No Gentamicin

☐ Yes ☐ No Tobramycin

☐ Yes ☐ No Vancomycin

☐ Yes ☐ No **Are you receiving any IV Drugs?** *If "Yes," answer next three questions.*

- Have you taken the antifungal drug Amphotericin B (not including Ambisome) intravenously for 2 days or more? ☐ Yes ☐ No
- Have you taken the chemotherapy drug Methotrexate within the past 3 days? ☐ Yes ☐ No
- Have you taken the chemotherapy drug Cisplatin within the past 3 weeks? ☐ Yes ☐ No

** *"Yes" answers require Creatinine/eGFR labs to be drawn within 24 hrs of appointment.*

Breast MRI Patients Only: Do you still get your period? ☐ Yes ☐ No If yes, date of last menstrual period: ____________

Have you had a previous outside mammogram or MRI? ☐ Yes ☐ No If yes, where? ____________

Informed patient to bring outside images to their appointment? ☐ Yes ☐ No

(Screening Breast MRI exams must be performed within the 7-14 day period of menstrual cycle.)

For phone screen patients only: A technologist may need to call you tomorrow to gather more information prior to your exam.

The best number to reach you at is: ____________

For all patients: The MRI Technologist will review this screening form with you prior to performing your test.

For cancellations or additional questions, please call:

Breast MRI 617-983-4879

MRI 617-983-4479

To pre-register by phone: 855-890-9242

To pre-register online (must be 24 hours in advance):

www.brighamandwomensfaulkner.org

Recent Lab Draw Date: ____________ **eGFR:** ____________ **Creatinine:** ____________

Technologist reviewing with patient: ____________ **Date:** ____________ **Time:** ____________