Name

MRN

VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298

(Patient Identification)

## **MRI Safety Checklist**

1.	Have you had an MRI?		No	Yes_
	Did you have any difficulty related to the procedure?			
_	If yes, please describe:			<del></del> -
	Do you have or have you had a pacemaker, ICD or defibrillator?			
3.	Have you ever worked with grinding metals or had metal fragmen	nts in your eyes?	No	_ Yes
	Have you ever had a reaction or ill effect from MRI contrast mater If yes, please describe:	-		
5.	Do you have medicine or food allergies?		No	Yes _
6.	Do you have sickle cell disease?		No	Yes
7.	If yes, are you in sickle cell crisis?			
	Do you have kidney (renal) problems or a kidney transplant?			
o. 9.	Have you been told your kidneys are not working properly?		NO	_ 165
	Are you on kidney dialysis?			
11	Female Patients Only: Is there a nossibility that you might be no	ennant?	No	_ 163
11. <b>Female Patients Only:</b> Is there a possibility that you might be pregnant?			No	_ 103 Vae
	e MRI magnet is ALWAYS on.		RI room.	
		Dogoribo		
	you have or have you had? (Circle <u>No</u> or <u>Yes</u> )	Describe:		
Vas	you have or have you had? (Circle No or Yes) urysm clips, coil or graft	No / Yes		
	you have or have you had? (Circle No or Yes) eurysm clips, coil or graft cular stent, coil, clips or clamps	No / Yes No / Yes		
Car	you have or have you had? (Circle No or Yes) eurysm clips, coil or graft cular stent, coil, clips or clamps diovascular catheter / Swan-Ganz catheter	No / Yes No / Yes No / Yes		
Car Hea	you have or have you had? (Circle No or Yes)  urysm clips, coil or graft  cular stent, coil, clips or clamps  diovascular catheter / Swan-Ganz catheter  urt valve replacement	No / Yes No / Yes No / Yes		
Car Hea Imp	you have or have you had? (Circle No or Yes) eurysm clips, coil or graft cular stent, coil, clips or clamps diovascular catheter / Swan-Ganz catheter ert valve replacement lanted filter (i.e. Inferior Vena Cava filter)	No / Yes No / Yes No / Yes No / Yes		
Car Hea Imp Bra	you have or have you had? (Circle No or Yes)  urysm clips, coil or graft	No / Yes No / Yes No / Yes No / Yes No / Yes		
Car Hea Imp Bra Imp	you have or have you had? (Circle No or Yes) eurysm clips, coil or graft cular stent, coil, clips or clamps diovascular catheter / Swan-Ganz catheter ert valve replacement lanted filter (i.e. Inferior Vena Cava filter)	No / Yes No / Yes No / Yes No / Yes h)No / Yes		
Car Hea Imp Bra Imp Imp	you have or have you had? (Circle No or Yes)  urysm clips, coil or graft	No / Yes No / Yes No / Yes No / Yes h)No / Yes No / Yes		
Car Hea Imp Bra Imp Imp Pro Mag	you have or have you had? (Circle No or Yes)  ourysm clips, coil or graft	No / Yes No / Yes No / Yes No / Yes h)No / Yes No / Yes No / Yes No / Yes		
Car Hea Imp Imp Imp Mag Inte	you have or have you had? (Circle No or Yes)  Purysm clips, coil or graft	No / Yes No / Yes No / Yes No / Yes h)No / Yes No / Yes No / Yes No / Yes No / Yes		
Car Hea Imp Bra Imp Pro Maq Inte Epid	you have or have you had? (Circle No or Yes)  ourysm clips, coil or graft	No / Yes No / Yes No / Yes No / Yes h)No / Yes No / Yes No / Yes No / Yes No / Yes No / Yes No / Yes		
Car Hea Imp Bra Imp Pro Maç Inte Epic Sta	you have or have you had? (Circle No or Yes)  ourysm clips, coil or graft	No / Yes No / Yes No / Yes No / Yes h)No / Yes No / Yes		
Car Hea Imp Bra Imp Pro Maç Inte Epid Sta Eye	you have or have you had? (Circle No or Yes)  eurysm clips, coil or graft	No / Yes No / Yes No / Yes No / Yes h)No / Yes No / Yes		
Car Hea Imp Bra Imp Imp Pro Maç Inte Epid Eye Inte	you have or have you had? (Circle No or Yes)  ourysm clips, coil or graft	No / Yes		
Car Hea Imp Bra Imp Imp Pro Maç Inte Epid Sta Eye Inte Med	you have or have you had? (Circle No or Yes)  ourysm clips, coil or graft	No / Yes		
Car Hea Imp Bra Imp Pro Maç Inte Epid Eye Inte Med Anti	you have or have you had? (Circle No or Yes)  ourysm clips, coil or graft	No / YesNo / Yes		

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(Patient Identification)	MRI Safety Checklist	
Do you have or have you had? (Circle No or Yes)	Describe:	
Dental implant, dentures or partial plates		
Intrauterine Device (IUD)		
Penile implant		
Bullet or metallic fragments		
Tissue expander (i.e. breast expander)	No / Yes	
Permanent make-up, tattoo, piercing		
Hearing aid (remove before entering the MRI room)		
Artificial or prosthetic limb	No / Yes	
Joint replacement or resurfacing		
Any other type of device, implant or prosthesis not listed above:		
List all operations you have had:		
Weight: Height:		
Signature: Relations  (Patient, guardian, or designee)  Inpatients Only: Nurse or MD responsible for reviewing for	ship to patient: m's completeness and accuracy:	
	Date: Time:	
Printed Name (RN, MD) Signature (RN, MD)		
Signature (First, ME)		
Radiology verification of form accuracy and patient safety review:	Date: Time:	
	Date:Time:	
Radiology verification of form accuracy and patient safety review:	gist)	 I
Radiology verification of form accuracy and patient safety review:  Printed Name (Technologist/Radiologist)  Signature (Technologist/Radiolog	w this line	 I
Radiology verification of form accuracy and patient safety review:  Printed Name (Technologist/Radiologist)  Signature (Technologist/Radiologist)  For staff use only below	w this line	 I
Radiology verification of form accuracy and patient safety review:  Printed Name (Technologist/Radiologist)  Signature (Technologist/Radiolog  For staff use only below  If renal problems, diabetes, or age >65, blood work should be within 3	w this line 30 days for IV contrast.	 <b>I</b>
Radiology verification of form accuracy and patient safety review:  Printed Name (Technologist/Radiologist)  Signature (Technologist/Radiologist)  For staff use only below  If renal problems, diabetes, or age >65, blood work should be within 3  eGFR (estimated Glomerular Filtration Rate)	w this line 30 days for IV contrast.  Creatinine Source:POCTLab	<b>I</b>
Radiology verification of form accuracy and patient safety review:  Printed Name (Technologist/Radiologist)  Signature (Technologist/Radiologist)  For staff use only below  If renal problems, diabetes, or age >65, blood work should be within 3  eGFR (estimated Glomerular Filtration Rate )  Date of result:  If GFR < 60 or yes to renal problems / transplant / dialysis and contrast	w this line  30 days for IV contrast.  Creatinine  Source: POCT Lab  st is required, was the information sheet regarding of	<b>I</b>
Radiology verification of form accuracy and patient safety review:  Printed Name (Technologist/Radiologist)  For staff use only below  If renal problems, diabetes, or age >65, blood work should be within 3  eGFR (estimated Glomerular Filtration Rate )  Date of result:  If GFR < 60 or yes to renal problems / transplant / dialysis and contrasgiven to the patient? Yes / No	w this line  30 days for IV contrast.  Creatinine  Source: POCT Lab  st is required, was the information sheet regarding of	gadolinium
Radiology verification of form accuracy and patient safety review:  Printed Name (Technologist/Radiologist)  For staff use only below  If renal problems, diabetes, or age >65, blood work should be within 3  eGFR (estimated Glomerular Filtration Rate )  Date of result:  If GFR < 60 or yes to renal problems / transplant / dialysis and contrasgiven to the patient? Yes / No  Tech initials If no, explain	w this line  30 days for IV contrast.  Creatinine  Source: POCT Lab  st is required, was the information sheet regarding of the contract of the	gadolinium
Radiology verification of form accuracy and patient safety review:  Printed Name (Technologist/Radiologist)  For staff use only below  If renal problems, diabetes, or age >65, blood work should be within 3  eGFR (estimated Glomerular Filtration Rate)  Date of result:  If GFR < 60 or yes to renal problems / transplant / dialysis and contrasgiven to the patient? Yes / No  Tech initials  If no, explain  Gadolinium given: Yes No CONTRAST:	w this line  30 days for IV contrast.  Creatinine  Source: POCT Lab  st is required, was the information sheet regarding of the contract of the	gadolinium