Rutland Regional Medical Center
An Affiliate of Rutland Regional Health Services
160 Allen Street
Rutland, VT 05701
802.775.7111

Outpatient MRI Order/ Prescreening Questionnaire

Upon completion, please fax to central scheduling at 776-3301.
(For Breast MRI only, fax to Breast Care Program at 747-6595.)

Patient Name: _____ Date of Birth: _____
Patient Phone (8am-4pm) _____ Referring Physician: _____
Can we leave a message? ☐ Yes ☐ No **Physician Signature**: _____
(If not, please have patient call us the next business day 747-1707.) **Date and Time**: _____
☐77002 Fluoroscopy for needle placement for MR arthrogram injection ☐ MR Arthrogram _____

Type of MRI ordered: _____ IV contrast ☐with ☐ without ☐with and without
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? ☐ minimal (anxiolysis) ☐ moderate
		Is patient ≥ 60 years of age? ☐ Yes ☐ No Patient weight: _____ Is patient diabetic? ☐ Yes ☐ No Patient height: _____ **If the patient is diabetic or over 60years of age a BUN and Creatinine is required (within 90 days) if patient is receiving contrast.** BUN_____ CREATININE_____ DATE_____
		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 on day of exam).
		Has patient had any recent prior surgery, as MRIs should be done 4-8 weeks after most surgery? (If 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? ☐Yes ☐No Is patient a nursing mother? ☐Yes ☐No
		Does patient have difficulty lying flat on his/her back or stomach? If so, which?_____
		ONLY FOR MRI OF BREAST: Is patient on hormone replacement therapy (HRT)? If yes, patient needs to be off HRT for 6 weeks before MRI is performed. Date of last dose: _____ First day of last menstrual period: _____ Date next period expected: _____ MRI must be at least 6 months after end of radiation treatment; at least 1 year after end of chemotherapy.

Above portion completed by_____ Date/Time _____

TO BE COMPLETED BY CENTRAL SCHEDULING:

MRUN: _____ Booked by: _____ Date/Time: _____ Confirmation #: _____
Other Exams: _____ **MRI scheduled for**:_____

Form # 2772 Rev. 03/08; 05/08, 09/08, 12/08, 5/09