MRI- Females Only
Outpatient Registration Checklist

Thank you for choosing Baylor Diagnostic Imaging Center and The Women’s Imaging Center for your upcoming procedure(s). Baylor Medical Center at Carrollton respects your time and strives to provide you with very good care. To help expedite the registration process and to reduce your wait time in registration, please bring the following completed items with you to your appointment:

- Completed Outpatient Preregistration forms for your scheduled test or procedure
  1. MRI Outpatient Registration Checklist (this form)
  2. Magnetic Resonance Imaging (MRI) Screening Form
  3. Outpatient Questionnaire/ Falls Assessment
  4. Radiology Screening, Childbearing Age (females 12-55 years of age only)
  5. Ionizing Radiation Pregnancy Consent for Treatment (females 12-55 years of age only)
- Insurance Card
- Government Issued Identification
- Insurance co-payment
- Physician orders, if applicable

Baylor Diagnostic Imaging Center at Carrollton and The Women’s Imaging Center provide many diagnostic and screening procedures. Every procedure is overseen by a specialist who will provide patient-centered care. As people are all different, the amount of time each individual needs for their procedure is also different. Please don’t be concerned if you are taken to the testing area before someone who arrived prior to you. We will strive to provide each patient with the specialized care they deserve which can cause some fluctuations in the amount of time needed for each test. We will be sensitive to the needs of all of our patients - all of the time.

Below is the average amount of time spent in the testing area for the most common procedures:

- Screening Mammograms: 20 minutes
- Diagnostic Mammograms: 60 minutes
- CAT Scans: 30 minutes
- X-Rays: 15 minutes
- MRI: 45 to 60 minutes
- Bone Density Screenings: 15 minutes
- Biopsy: 90 to 120 minutes

Please understand these are average times and could vary.
Magnetic Resonance Imaging
SCREENING FORM

The information requested on this form is very important. Please answer all questions as thoroughly as possible. The patient or patient’s legally authorized representative is responsible for the accuracy of the requested information.

Do you have any of the items or conditions listed below? Please check “Yes” or “No” for each item or condition. You will see the words “Location:” or “Date:” next to some items. If you see the word “Location:” next to an item that you have, please write in where the item is located on your body. If you see the word “Date:” next to an item that you have, please write in the date that you received the item.

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient weight:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANY metal inside your body anywhere?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cardiac pacemaker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implanted defibrillator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aneurism clips Location:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carotid artery clips Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Surgeries?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical staples, clips or metallic sutures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magnetically activated implant or device?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal electrodes or wires Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stent, coil or filter (please circle) Location:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artificial heart valve Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Silver impregnated wound dressing Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shunt: spinal or ventricular Other implants? Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fractured bones or spine treated with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metal rod</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metal plates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metal pins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screws</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tattoos/permanent makeup Location:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body piercing Location:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metal in eyes Location:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Right Both</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metal fragments (shrapnel or gunshot wound) Location:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location: Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you claustrophobic (nervous in small places)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you pregnant or trying to get pregnant?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you breast feeding?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No one should enter the MRI scan room with any of the following items:

- Watch
- Metal Zippers
- Firearms
- Removable Dental Work
- Hearing Aid
- Keys/Coins
- Pocket Knife
- Hairpins/Accessories
- Pens/Pencils
- Belt Buckle
- Bra
- Purse/Wallet/Money Clip

Signature of person completing form: X Date: Time:
Form completed by (check one): ☐ Patient ☐ Relative ☐ Nurse ☐ Other

MRI STAFF: Were plain films obtained? Films cleared by:

Contrast: Amount: Lot #: Expiration: 
Signature of person reviewing form and checking patient for unsafe external objects prior to entering scan room: X Date: Time:
Form reviewed by (check one): ☐ Technologist ☐ Radiologist
☐Equipment Checked ☐ Form Checked ☐ Patient Checked ☐ Staff Checked

SAFETY CONTROL CHECK PERFORMED BY __________ Date: Time: __________

MRI SCREENING FORM

* «PatientNumber» *
ACCT# «PatientNumber» MR# «MedicalRecordNumber» «AdmitDate»
REV: 08/4/11
OUTPATIENT QUESTIONNAIRE/ FALLS ASSESSMENT

Please answer the following questions:

**Fall Risk Assessment**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

What is one thing that I can do for you to make sure that you get very good care today?

_________________________________________________________________________________

Are there any special needs/considerations that we should know about?

_________________________________________________________________________________

_________________________________________________________________________________

Patient Signature ____________________________ Date _______________ Time _______________

Authorized Representative ____________________________ Relationship ____________________________ Date _______________ Time _______________

FOR STAFF USE ONLY:

☐ Patient is at high risk for falls. (Check if any answer above is ‘Yes’.)

**Actions Taken:**

☐ Patient given facility specific fall precaution identification.

☐ Escorted Patient under their own power.

☐ Escorted Patient by wheelchair.

☐ Patient used their own cane/walker or other device.

☐ Instructed Patient that a staff member should be present each time they ambulate while in the facility.

STAFF SIGNATURE ____________________________ DATE _______________ TIME _______________

OUTPATIENT FALLS ASSESSMENT

*«PatientNumber»*
This form must be completed for/by all female patients who have menstruated and could possibly be or become pregnant. Although most standard radiology procedures cause low, non-harmful levels of radiation exposure to a fetus, more specialized procedures that utilize higher radiation doses may pose an increased health risk to a fetus, depending upon the type of procedure, location on the female's body (e.g., pelvis, abdomen), radiation dose, and stage of pregnancy. The following information will help your health care provider assess and discuss with you the risks, benefits, and alternatives of performing or postponing the radiology procedure that has been ordered by your physician or whether a different or limited radiology procedure is available. This form will be retained with your medical records. The information provided by you will be used or disclosed only in accordance with federal or state law.

Name

LAST
FIRST
MIDDLE

Date of Birth: _______ / _______ / _______  Age: _______

Date of Last Menstrual Cycle: ________________________________

1. Are you pregnant?  ☐ Yes  ☐ No  ☐ Maybe
2. Could you be pregnant?  ☐ Yes  ☐ No  ☐ Maybe
3. Are you currently breast feeding?  ☐ Yes  ☐ No
4. Do you have history of a tubal ligation, and/or a hysterectomy and/or menopause?  ☐ Yes  ☐ No

I have read and understood the above information and the above information is correct.

______________________________  __________________  ________________
Signature Patient/Legal Representative  Date  Time

______________________________
Printed Name Patient/Legal Representative

RAD SCREENING-CHILDBEARING AGE FEMALES

REV: 07/22/2010
Female patients who are pregnant or suspect that they may be pregnant should not have an exam that utilizes ionizing radiation unless the patient's ordering physician determines the exam is medically necessary and the patient consents to the exam after having had the risks, benefits, and alternatives explained. If possible, confirmation of pregnancy/non-pregnancy for females who could possibly be or become pregnant is important prior to performing an ionizing radiological exam. Although most standard ionizing radiation procedures cause low, non-harmful levels of radiation exposure to a fetus, more specialized procedures that utilize higher radiation doses may pose an increased health risk to a fetus, depending on the type of procedure, location on the female's body (e.g., pelvis, abdomen), radiation dose, and stage of pregnancy.

**I. UNCLEAR PREGNANCY STATUS** (Please check and initial all that apply below)

- [ ] I am unsure of my pregnancy status
- [ ] I have decided to delay or reschedule the exam/procedure until my pregnancy status is confirmed. Facility staff will notify my ordering physician of the delay or rescheduling of my exam.
- [ ] I am requesting that the facility perform a pregnancy test at my expense.
- [ ] I am unsure of my status and have declined a pregnancy test. I have decided to have the exam with ionizing radiation and I understand the risks, benefits, and alternatives involved.

By signing below I agree that these statements are true: (a) I've had the opportunity for a physician to discuss the risks, benefits, and alternatives of the ionizing radiation procedure/exam with me, (b) I have had the opportunity to ask questions of the physician, and (c) I hereby release the Baylor Health Care System and this facility from any complications that may occur from my decision to delay, reschedule or undergo the ionizing radiation procedure/exam.

**II. POSITIVE PREGNANCY STATUS** (Please check and initial all that apply below)

- [ ] I am pregnant or have had a positive pregnancy test, and I have decided to delay or reschedule the exam/procedure until I have had a chance to discuss this exam further with my referring physician.
- [ ] I am pregnant and I have consented to undergo the exam with ionizing radiation with the knowledge of the risks, benefits, and alternatives to my unborn fetus and I understand the risks, benefits, and alternatives involved.

By signing below I agree that these statements are true: (a) I've had the opportunity for a physician to discuss the risks, benefits, and alternatives of the ionizing radiation procedure/exam with me, (b) I have had the opportunity to ask questions of the physician, and (c) I hereby release the Baylor Health Care System and this facility from any complications that may occur from my decision to delay, reschedule or undergo the ionizing radiation procedure/exam.