*1QUEST*

CHESAPEAKE REGIONAL HEALTHCARE

# MRI OUTPATIENT SAFETY QUESTIONAIRE

| NAME | DOB: |
|---|---|
| | HEIGHT: |
| | WEIGHT: |

**WARNING: CERTAIN IMPLANTS, DEVICES, OR OBJECTS MAY BE HAZARDOUS TO YOU AND MAY INTERFERE WITH THE MR PROCEDURE. DO NOT ENTER THE MR ENVIRONMENT IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING IMPLANT, DEVICE, OR OBJECT. THE MR SYSTEM IS ALWAYS ON!**

| PLEASE ANSWER TO BEST OF YOUR KNOWLEDGE THE FOLLOWING: | | | *PROVIDE ADD. INFO.* |
|---|---|---|---|
| ANY PROBLEMS RELATED TO PRIOR MRI | YES | NO | |
| ALLERGY TO MEDICATION/FOOD | YES | NO | |
| HISTORY OF ASTHMA/COPD | YES | NO | |
| ALLERGY TO CONTRAST MEDIA | YES | NO | |
| HISTORY OF SICKLE CELL DISEASE | YES | NO | |
| HISTORY OF HYPERTENSION (HIGH BLOOD PRESSURE) | YES | NO | |
| HISTORY OF RENAL DISEASE (INFECTION, STONES, INSUFFICIENCY) | YES | NO | |
| HISTORY OF KIDNEY FAILURE | YES | NO | |
| HISTORY OF DIABETES | YES | NO | |
| TREATMENT: DIET, GLUCOPHAGE, GLUCOPHAGE XR, AVANDAMENT, METFORMIN, METAGLIP, GLUCOVANCE, JANUMET, OTHER | | | |
| RECENT USE OF NSAIDS | YES | NO | |
| ADVIL, ALEVE, ANSAID, CATAFLAM, CELEBREX, CLINORIL,DAYPRO, DOLOBID, FELDENE, INDOCIN, LIDINE, MOBIC, MOTRIN, NAPROSYN, NALFON, ORUDIS, ORUVAIL, PONSTEL, RELAFEN, TOLECTIN, VOLTAREN | | | |
| REGULAR USE OF NEPHROTOXIC ANTIBIOTICS | YES | NO | |
| NEOMYCIN, KANAMYCIN, PAROMOMYCIN, BACITRACIN, AMPHOTERICIN B | | | |
| EYE INJURY INVOLVING METAL | YES | NO | |
| ANY METALLIC FOREIGN BODY (HEAD, EYE, OR BODY) | | | |
| WAR INJURY/GUNSHOT WOUND | YES | NO | |
| **CARDIAC PACEMAKER OR WIRES** | YES | NO | |
| **IMPLANTED CARDIAC DEFIBRILLATOR** | YES | NO | |
| **ARTIFICAL HEART VALVE** | YES | NO | |
| METALLIC STENT, FILTER OR COIL | YES | NO | |
| **CORONARY ARTERY VASCULAR STENTS, HEART STENTS** | YES | NO | |
| IMPLANTED VASCULAR (BLOOD VESSEL) DEVICE OR CATHETER | YES | NO | |
| **BRAIN ANEURYSM CLIPS** | YES | NO | |
| BRAIN SURGERY | YES | NO | |
| SHUNT | YES | NO | |
| ARTIFICAL EYE, EYELID SPRING OR WIRE | YES | NO | |
| INNER EAR SURGERY | YES | NO | |
| EAR/COCHLEAR IMPLANTS OR WIRES | YES | NO | |
| REMOVABLE HEARING AID, PLEASE REMOVE PRIOR TO ENTERING ROOM | YES | NO | |
| NEUROSTIMULATOR OR BIOSTIMULATOR (TENS UNIT) | YES | NO | |
| SPINAL CORD STIMULATOR | YES | NO. | |
| INTERNAL ELECTRODES OR WIRES | YES | NO | |
| BONE GROWTH/FUSION STIMULATOR | YES | NO | |
| MAGNETICALLY ACTIVATED IMPLANT OR DEVICE | YES | NO | |
| ELECTRONIC IMPLANT OR DEVICE | YES | NO | |
| IMPLANTED MEDICATION INFUSION DEVICE/PUMP | YES | NO | |
| MEDICATION PATCHES | YES | NO | |

MRI OUTPATIENT SAFETY QUESTIONAIRE

*NAME LABEL HERE*

*1QUEST*

CHESAPEAKE REGIONAL HEALTHCARE

**WARNING: CERTAIN IMPLANTS, DEVICES, OR OBJECTS MAY BE HAZARDOUS TO YOU AND MAY IN MR PROCEDURE. DO NOT ENTER THE MR ENVIRONMENT IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING IMPLANT, DEVICE, OR OBJECT. THE MR SYSTEM IS ALWAYS ON!**

| | | | *PROVIDE ADD. INFO.* |
|---|---|---|---|
| HISTORY OF CANCER/TUMORS | YES | NO | |
| HISTORY OF SURGICAL PROCEDURES | YES | NO | |
| IMPLANTED ORTHOPEDIC DEVICE | YES | NO | |
| ARTIFICIAL/PROSTHETIC LIMB OR JOINT | YES | NO | |
| SURGICAL STAPLES, CLIPS, OR METALLIC SUTURES | YES | NO | |
| WIRE MESH IMPLANT | YES | NO | |
| BREAST IMPLANT OR TISSUE EXPANDER | YES | NO | |
| RADIATION SEEDS | YES | NO | |
| SMALL BOWEL ENDOSCOPE/CAMERA | YES | NO | |
| CLAUSTROPHOBIC | YES | NO | |
| LATEX ALLERGY | YES | NO | |
| BRACES/MAGNETIC DENTAL IMPLANTS | YES | NO | |
| TATTOOS AND/OR BODY PIERCING | YES | NO | |
| CURRENTLY TAKING FERAHEME (FERUMOXYTOL) | YES | NO | |
| ASTHMA/HAYFEVER/COPD/EMPHYSEMA | YES | NO | |
| FEMALE PATIENTS | | | |
| PREGNANT | YES | NO | |
| BREASTFEEDING | YES | NO | |
| LMP | | | DATE |
| IUD | YES | NO | |
| HORMONE REPLACEMENT | YES | NO | |
| MALE PATIENTS | | | |
| PENILE IMPLANT | YES | NO | |

**I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.**
**I READ AND UNDERSTAND THE CONTENTS OF THIS FORM AND HAD THE OPORTUNITY TO ASK QUESTIONS.**

| SIGNATURE | DATE |
|---|---|
| | |

FORM COMPLETED BY: ( )PATIENT ( )FAMILY MEMBER ( )NURSE ( )OTHER

**REMOVE ALL HAIRPINS, BODY PEIRCINGS, JEWELRY, MONEY, CREDIT CARDS, ETC. PRIOR TO MRI SCAN. MEDICATION PUMPS AND CARDIAC MONITORS MUST BE DISCONNECTED.**

DESCRIBE YOUR PROBLEM AND HOW LONG YOU HAVE HAD IT: _____

IS THIS A RESULT OF INJURY: ( ) YES ( ) NO

HAVE YOU HAD SURGERY FOR THIS PROBLEM: ( ) YES ( ) NO

PLEASE LIST ALL PRIOR SURGERIES: _____

HAVE YOU HAD ANY OTHER TESTS FOR THIS PROBLEM? _____



ACCT#

DOB ACCT

PT

MR#

CHESAPEAKE REGIONAL
MEDICAL CENTER

*1MEDREC*

# Outpatient Medication Reconciliation Form

**Patient Name** _____ **Date/Time** _____

(A) **This form is for informational purposes only and NOT to be used as a Physician Order. It is NOT to be used for inpatient admissions.**

(B) **This is NOT a prescription. It is a list of your medications and new orders.**

(C) **If you have any questions regarding any medications listed on this form, or about any medications you may have been on before coming to the hospital, please call your Primary Physician.**

(D) **If your physician needs another copy of this list, please have him/her call Health Information Services at: 757-312-6114.**

## Part A

Do Not Use: **U, QD, qd, MS, MSO4, MgSO4, D, Leading Decimal (.X mg), Trailing Zero (X.0 mg), IU, QOD, µg**

| Medication Name | Time of last dose | Continue | Discontinue |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Part B

**Information collected by:** _____

- ☐ Copy given to patient
- ☐ Patient/Caregiver Signature:_____
- ☐ Next provider of care: Dr._____
- ☐ Copy faxed to CRMC Health Information Services at 312-6644.
- ☐ Copy hand delivered to CRMC Health Information Services at 312-6644.

### New Prescriptions Ordered and Given to Patient

| |
|---|
| |
| |
| |
| |

**Nurse:**_____ **Date/Time:**_____

White-Medical Record Yellow-Patient

ACCT#



DOB

ACCT

PT

MR#