Saskatchewan Health Authority

Saskatoon Cancer Centre - TST: 306-655-2662/Fax: 306-655-2910

MOCK, Colleen
HSN: 123456788 SCA: T123456
DOB: 01-JAN-1970 AGE: 50 Years
Gender: Female
123 Happy Lane
Regina, SK S4S4S4
Phone#: 306-303-0303 Cell#: 306-404-0404

MRI Consultation Requisition

City and Location of Booking: _____

Test / Procedure Requested:

MRI (Head)

Priority: Urgent

Height: 160 cms Weight: 60 kg

Isolation Precautions:
No

Creatinine:

Diagnosis / Clinical Indication:
Breast Ca, ? progression

See page 2 for screening

Electronically Signed by: TEST, Dr. MD Date: 18-DEC-2020

Send Report to Oncologist: TEST, Dr. MD

DEPARTMENT USE ONLY

Date Received : _____ Clerk: _____

Appointment Date: _____ Appointment Time: _____

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❑ RUH ❑ SCH ❑ SPH ❑ Other _____

MEDICAL IMAGING

MRI OUTPATIENT SAFETY SCREENING QUESTIONNAIRE

❑ OP ❑ IP ❑ GA

Booked date: _____ **Time:** _____ ❑ AM ❑ PM

Office use only: Require physiological monitoring, sedation, analgesia, or direct nursing care? ❑ Yes ❑ No
Meets NSF risk criteria and may require serum creatinine testing? See over. ❑ Yes ❑ No

Yes	No	
		Have you had a previous MRI examination? If yes, when? _____ Where? _____
		Have you had any abdominal, chest, or heart surgery or procedures? If yes, did you have a colonoscopy or gastroscopy? If yes, did they snare, biopsy, or clip anything in the bowel or stomach? Do you have a cardiac pacemaker, pacemaker leads, coronary artery stent, vessel coils or filters, cardiac defibrillator, prosthetic heart valve, etc. implanted in your body? Please list/describe: _____
		Have you had any head, neck, spine, or brain surgery or procedures? If yes, do you have intracranial aneurysm clip, cochlear implants, intra-ventricular drain, valve or VP shunt (adjustable?), brain/spine stimulator, etc.? Please list/describe: _____
		Have you had any orthopedic devices such as metal rods, pins, or screws implanted in your body? If yes, please list/describe: _____
		Have you had any other surgery or procedures? Please list/describe: _____ If so, did they use any metallic clips, sutures, staples, etc.? ❑ Yes ❑ No
		Do you have electronic pumps, electrodes, prosthesis, or other devices implanted or attached to or near your body? Example: IUD, diabetic pump, pain pump, ear (cochlear) or eye implant, etc. Please list/describe: _____
		Have you ever had a known foreign body in your eye or felt something strike your eye during welding, grinding, metalworking, etc. and could not confirm you or your physician removed it successfully? If yes, explain: _____
		Have you ever had any metal or shrapnel pierce/enter your body from a motor-vehicle accident, industrial accident, or war injury? If yes, explain: _____
		Are you claustrophobic? If yes: - Will you require sedation for the procedure? ❑ Yes ❑ No ❑ Don't know - Will you supply your own from your family doctor? ❑ Yes ❑ No
		Are you experiencing significant pain, which could make this test difficult for you? Will you require an analgesic (pain medication)? If yes, please take it 30 minutes before or have it available at your appointment time.
		Can you walk? (ambulatory, cane, walker, walk with assistance, wheelchair, need mechanical lift)
		Can you lay flat on your back without moving, with only a thin pillow for a minimum of 30 minutes?
		Do you have any dentures, hearing aids, or a wig? If so, they must be removed prior to the MRI scan.
		Is there any chance you might be pregnant? If yes, when is your due date? _____ or LMP _____
		Do you have any body piercing(s) or tattoos?
		Do you use any trans-dermal medication patches or silver nitrate dressings? If so they must be removed prior to scanning.

What is your height? _____ ❑ Feet/Inches ❑ Meters **What is your weight?** _____ ❑ Pounds ❑ Kg

Do you have any other concerns or comments about having an MRI scan? _____

This questionnaire was completed by: ❑ Patient ❑ Mother ❑ Father ❑ Sibling ❑ Guardian ❑ Nurse ❑ Other _____

If completed in person: **Patient/Guardian signature:** _____ **Date:** _____

Technologist/nurse signature: _____ **Date:** _____

PHONE SCREENED OUTPATIENTS ONLY: Do you know how to get here and where to park? ❑ Yes ❑ No ❑ N/A **OVER** →

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NSF RISK ASSESSMENT – FOR GADOLINIUM ENHANCED MRI EXAMINATIONS ONLY

Patients with significant renal (kidney) disease may be at an increased risk of developing NSF (nephrogenic systemic fibrosis), a serious but rare condition resulting in fibrosis of the skin, muscles, and internal organ. Exposure to MRI contrast (gadolinium) has been implicated in the development of NSF.

Yes	No	N/A	
			Have you ever been told you have protein in your urine or gout?
			Do you have a history of renal (kidney) disease or serious injury to the kidneys?
			Have you had a previous reaction to MR IV contrast?
			Are you diabetic?
			Do you have a history of hypertension (high blood pressure)?
			Have you ever been on kidney dialysis?

If you answered yes to any of the above questions you will need to have a serum creatinine level blood test obtained within a three (3) month period prior to your gadolinium enhanced MRI. It will be important for the result to be available for the radiologist on the day of the MRI to determine if it is safe to administer gadolinium. You may already have these results as part of a recent routine blood test and, if so, we will access those results. If not, we will arrange to have this done either at the hospital or a clinic of your choice. If you are already onsite, we will arrange for this to be done here today, before your MRI.

FOR OFFICE USE ONLY	
Lab Results	
Date of specimen collection:	
Serum Creatinine (µmol/L)	Reference range – adult male 60-104 µmol/L
	Reference range – adult female 45-90 µmol/L
eGFR (mL/min/1.73m²)	

OID:850000005 DID:850000005 R:OBS SCC SHFE MRI Screening Checklist P 2 S:2020-12-18 16:17:15:000 J:21

Five Hills Health Region

Diagnostic Imaging Department
MRI Patient Safety Screening Questionnaire

MOCK, Colleen
HSN: 123456788 SCA: T123456
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Gender: Female
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Phone#: 306-303-0303 Cell#: 306-404-0404

This form MUST be filled out by the patient/guardian with the Physician and MUST be signed when completed.

Booked Date: _____ **Time:** _____ **am/pm** □ **OP** □ **IP**

1. □ Y □ N Do you have a pacemaker or pacemaker leads? If yes, we CANNOT accommodate in Moose Jaw, please refer to RQHR.
2. □ Y □ N Have you had any **abdominal, chest** or **heart** surgery or procedures?
   If yes, **did you have a colonoscopy or gastroscopy?** If yes, did they snare, biopsy or clip anything in the bowel or stomach? Do you have a: coronary artery stent, vessel coils or filters, cardiac defibrillator, prosthetic heart valve, etc. implanted in your body? Please list/describe: _____
   _____
   _____
3. □ Y □ N Have you had any **head, neck, spine** or **brain** surgery or procedures?
   If yes, do you have: intracranial aneurysm clip, cochlear implants, intra-ventricular drain, valve or VP shunt (adjustable?), brain simulator, etc? Please list/describe: _____
   _____
   _____
4. □ Y □ N Have you had any **orthopedic devices** such as **metal rods, pins, screws**, implanted in your body?
   If yes please describe where in your body and when you had the surgery: _____
   _____
5. □ Y □ N Have you had any other surgery or procedures? Please list/describe: _____
   _____
6. □ Y □ N Do you have **electronic pumps, electrodes, prosthesis**, or **other devices** implanted or attached to or near your body? Example: IUD, diabetic pump, pain pump, ear (cochlear) or eye implant, etc. Please list/describe: _____
   _____
7. □ Y □ N Have you ever had a known **foreign body** in your eye or felt something strike your eye during **welding, grinding, metalworking**, etc. and could not confirm that you or your physician removed it successfully? If yes, explain: _____
   _____
8. □ Y □ N Have you ever had any **metal** or **shrapnel** pierce/enter your body from a **MVA, industrial accident**, or **war injury**? If yes, or don't know, explain: _____
9. □ Y □ N Are you **claustrophobic?**
   If **Yes** will you require sedation for the procedure? □ Y □ N □ Don't Know
   If **Yes** or **Don't Know**, please ask your physician for a prescription to bring with you to your appointment.
9. □ Y □ N Is there any chance that you might be **pregnant**? If yes when is your due date? _____
10. □ Y □ N Are you experiencing **significant pain** which could make this test difficult for you? Will you require an analgesic (pain medication)? If yes, please take it 30 minutes before or have it available at your appointment time.
11. □ Y □ N Can you **walk**? (ambulatory, cane, walker, walk with assistance, wheelchair, need mechanical lift) _____
12. □ Y □ N Can you **lay flat** on your back without moving, with only a thin pillow for a **minimum of 30 minutes**?
13. □ Y □ N Do you have any **dentures, hearing aides**, or a **wig**? If so, they must be removed prior to MRI scan.
14. □ Y □ N Do you have any body piercing(s), permanent eye makeup or tattoos? _____
15. □ Y □ N Do you use any **trans-dermal medication patches**? If so, they must be removed prior to scanning.
16. What is your **height**? ____ FT ____ IN / _____ METRES What is your **weight**? _____ lbs / _____ kgs

Do you have any other concerns or comments about having an MRI scan? _____
_____

This questionnaire was completed by (circle one): patient mother father sibling guardian nurse other: _____

If completed in person: Patient/Guardian Signature: x_____ Date: _____

Physician Signature: _____ Date: _____

Adopted from Saskatoon Health Region, Medical Imaging Department
Approved by Medical QA and Practitioner Advisory Committee – Dec 15, 2015
NF062 Double-Sided

MR-0037

For Gadolinium-Enhanced MRI Examinations Only – NSF RISK ASSESSMENT

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Patients with significant renal (kidney) disease may be at an increased risk of developing NSF (Nephrogenic Systemic Fibrosis), a serious but rare condition resulting in fibrosis of the skin, muscles, and internal organs Exposure to .MRI contrast (Gadolinium) has been implicated in the development of NSF.

1.	□ Y □ N	Is the patient over the age of 60?
2.	□ Y □ N	Do you have a history of renal (kidney) disease or serious injury to the kidneys?
3.	□ Y □ N	Do you have a history of liver disease?
4.	□ Y □ N	Are you diabetic?
5.	□ Y □ N	Have you had an organ transplant?
6.	□ Y □ N	Do you have a history of hypertension (high blood pressure)?
7.	□ Y □ N	Have you ever been on kidney dialysis?
8.	□ Y □ N	Do you have a history of vascular disease including stroke, heart attack, or peripheral vascular disease?
9.	□ Y □ N	Have you had recent chemotherapy (within 60 days)?

If you answered yes to any of the above you will need to have a **serum creatinine** level blood test obtained within a 3 months period prior to your gadolinium enhanced MRI. It will be important for that result to be available for the radiologist on the day of the MRI, to determine if it is safe to administer gadolinium. You may already have these results as part of a recent routine blood-test, and if so, we will access those results. If not we will arrange to have this done either at the hospital or a clinic of your choice.

For Office Use Only: LAB RESULTS

Date of Specimen Collection: _____

Serum Creatinine (umol/L):_____

eGFR (mL/min/1.73m^2): _____

Adopted from Saskatoon Health Region, Medical Imaging Department
Approved by Medical QA and Practitioner Advisory Committee – Dec 15, 2015
NF062 Double-Sided